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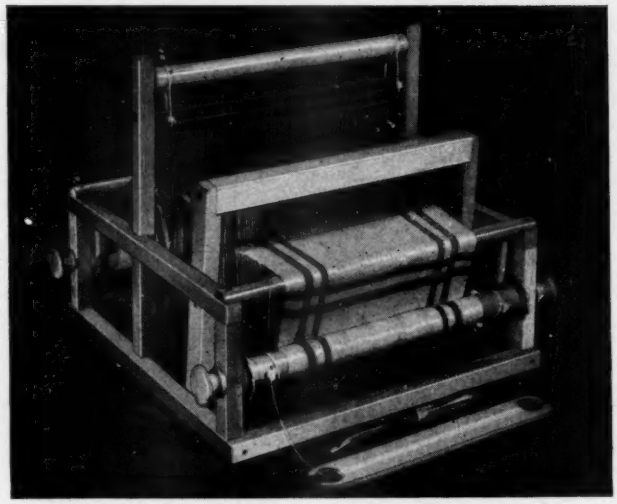

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THE AMERICAN JOURNAL

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OCCUPATIONAL THERAPY

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VOL. II, NO. 6 NOVEMBER-DECEMBER 1948

Techniques in the Rehabilitation of the Tuberculous

By HOLLAND HUDSON

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In recent years rehabilitation of the tuberculous has moved forward at a new pace. Some parts of the means by which this acceleration has been effected are applicable, no doubt, to the treatment of some other disabilities and thus have a claim on general interest.

The word "rehabilitation" has been applied by the press to so many processes of late, that we had best begin by referring to that definition of rehabilitation published by the National Council on Rehabilitation in 1943. Both the American Occupational Therapy Association and the National Tuberculosis Association are charter members of that Council.

"Rehabilitation," says this definition, "is the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable."

These terms are so broad they may include services ranging from assistance in the acceptance of diagnosis to a complete reorganization of the patient's way of life. Accordingly, rehabilitation which lives up to such a definition will enlist a variety of professional skills and is most unlikely to be accomplished by any single individual. Presently we shall review those skills which contribute most frequently and most substantially to the rehabilitation of the tuberculous. But first let us reexamine the nature of the disease involved in terms of the problems which it presents.

Tuberculosis is still the leading cause of death by disease among young adults. Let's repeat that sentence again, for some of the progress in the reduction of tuberculosis has occasionally been construed to mean that the total elimination of tuberculosis is just around the corner. Let's emphasize the fact that pulmonary tuberculosis is today relatively infrequently a disease of children and is some distance down the list of the diseases of old age. Primarily the patients confronting the occupational therapist in most tuberculosis hospitals which employ therapists, are young adults.

In terms of what is known about tuberculosis control, some of the optimism about complete tuberculoisis control is justified. We know the microorganism; we know the usual method of disease transmission; we know the therapies by which the disease may be arrested if diagnosis

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Read at the Annual Meeting of the American Occupational Therapy Association at New York, N. Y., September 8, 1948.

is sufficiently early in the progress of the disease. But the sum of this knowledge is frequently defeated by human ignorance and by human infirmity of purpose. For the present and for some time to come, pulmonary tuberculosis presents a formidable medical and public health task.

The task is sufficiently grave, costly, and exacting that the first questions one may ask concerning rehabilitation are what has it contributed or what may it contribute toward therapy in tuberculosis and toward the prevention of more tuberculosis. The record indicates that the processes which make up rehabilitation may assist substantially in the recovery of patients and that they may lessen the hazards of relapse, recurrence, and reactivation in a disease whose chronicity is one of its principal characteristics.

The disease "tuberculosis" is a condition of the body produced by the invasion of a microorganism, the tubercle bacillus, in force greater than the systemic resistance of the patient can cope with. It involves the destruction of tissues, particularly lung tissues, the generation of toxic substances, and the disturbance of functions in organs not directly infected. The basic treatment, today, is rest therapy. In a considerable majority of human adults, the innate resources of the body when at rest and suitably nourished have the capacity to resist the progress of the disease, to wall off the bacilli, and eventually to effect recovery to a comparatively healthy state. Collapse therapy and thoracic surgery are mechanical aids to rest therapy, introduced on individual prescription when the progress of the disease is beyond the capacities of the patient's resistance.

Streptomycin and other bacteriostatic discoveries may, in selected cases, retard and sometimes halt the spread of the disease in the body. It is unlikely that they will eliminate or take the place of that bed rest which is still essential to the general physical restoration of the patient and the permanence of medical result.

One of the principal obstacles to the control of tuberculosis is the very human behavior of tuberculous patients. For, in this highly communicable disease, the patient himself is the vector by which infection is transmitted from present cases to new cases. One case comes from another. Not mosquitoes, nor flies, nor other insects play the principal role in communication, but the patient himself, whose breath carries at one time or another, the paratrooper bacilli by which infection may be established in other persons.

For this reason, an isolation technique has become a part of the standard treatment of tuberculosis. Part of the treatment is to take the infective patient out of circulation long enough to reduce his opportunities to infect others, limiting his contacts to persons trained to maintain a routine of prophylaxis. Incidentally, a tuberculosis hospital, noisy and alien though it may be, may impose less wear and tear on a person sick with tuberculosis than any but the most exemplary home environment.

Neither rest therapy nor isolation has accomplished more than a part of what can be accomplished because too large a proportion of patients are unwilling or unable to cooperate in the medical program for their treatment. Departures of patients from tuberculosis hospitals against medical advice range from five to sixty per cent of admissions. I regret to state that in most institutions such departures are at the higher end of the scale. Occasionally we get into a flurry about some one institution or group of institutions, such as the hospitals of the Veterans' Administration, forgetting that this problem still confronts the majority of treatment centers.

The residual facts are that unless hospitals treating tuberculosis give sufficient thought and planning to the complete motivation of their patients, a minority of their patients will complete their treatment, whether the hospital is operated by federal agency, a state health department, a county, or a municipality. The reasons adduced by patients for departure against medical advice are many and various. Sometimes it is ascribed to institutional food, to economic problems in the home, to alleged deficiencies in medical care. Oftener than not, the actual motive is concealed behind a smoke screen of rationalization.

Currently, in *Good Housekeeping* magazine, Betty MacDonald, popular author of "The Egg and I," describes her adventures with tuberculosis under the title, "The Plague and I." This author's output is written to promote laughter and has some of the exaggeration of a cartoon style. The sanatorium described in the opening chapter may seem incredible to many readers. The sad fact is that quite a number of our treatment institutions are still about as screw-

ball as this one appeared to Betty MacDonald.

However, even under hospital conditions approaching the ideal, the acceptance and completion of treatment for pulmonary tuberculosis demand from the patient a sustained determination. Many persons who might endure the brief requirements of an acute illness with praiseworthy fortitude, are unable to endure month after month of the monotony of treatment indicated in this chronic illness. To bear up well under short intervals of pain and discomfort is one thing; to accept with equanimity months of daily boredom and irritation, quite another. May I suggest that infirmity of purpose is, in fact, a not unusual human trait in the general population?

Rehabilitation, which we have defined, can play a considerable role in the therapy of the patient and in the control of the disease by providing a satisfactory motivation for the acceptance and completion of treatment. Too often, while patients are assured that in time they can recover, what they see about them provides little reassurance. In some of their neighbors, disease continues to progress despite faithful bed rest. Death visits the sanatorium less often than many general hospitals, but the sanatorium "grape-vine" is far more proficient. If the patient's window does not command a view of the morgue exit, ward gossip makes up the deficiency. Gossip also informs the patient of some skeptic whose willful departure from the sanatorium was followed, not by dire results, but by considerable improvement. Bit-by-bit, the influence of our teaching about methods for recovery and about consideration for others becomes more tenuous.

To an audience of experienced occupational therapists, the initial treament of the patient's irritation is clear enough. In our better tuberculosis hospitals, the occupational therapist, as a member of the rehabilitation team, studies the adjustment of the patient to his hospital environment. Her colleague, the medical social worker, studies the anxieties and the personal and social problems which may obstruct cooperation in treatment. The therapist, on the other hand, is concerned with the resources and habits of the patient. Usually, a patient with well-established reading habits and with an extensive repertoire of quiet recreations can endure long hospitalization far more easily than one who lacks such equipment.

Studies of extensive samplings of patient groups disclose that few patients have established reading habits; fewer have learned to listen to music, and the characteristic recreational pattern tends toward violent sports and late hours rather than to relaxing types of diversion. Some of us have been too timid concerning the word "diversion." What it represents is an indispensable factor in individual mental hygiene. Often our diversions contribute most to what emotional stability we enjoy. Even when we work and sleep long hours, a considerable portion of the day remains in which suitable diversion can improve our ability to function. To a tuberculous patient with time on his hands, suitable diversion is very often quite literally a matter of life or death.

The therapeutic and preventive possibilities in occupational therapy, however, extend considerably beyond the interval of hospitalization. The patient comes to the hospital frequently with habit patterns which have contributed to lowering the threshold of his resistance to the disease. For example, while our knowledge of resistance is limited, we observe that frequent physical exhaustion is a condition predisposing to infection and to recurrence of old disease. We note that many patients, male and female, have habits of work and play in which things are done the hard way. I am not discussing the difference between a wash-board and an electric washing machine now, but the difference between attacking any task haphazardly, jerkily, and forcibly or smoothly and methodically.

Habit formation, whether in the child or the adult, is a day-by-day accretion of minute experiences. A patient who has been exposed to several months of well-planned occupational therapy may experience a substantial and lasting modification of his ways of going about things which further improves his chances of holding his own.

It is this concern with long-time result which enriches the opportunities of the occupational therapist as a member of a tuberculosis rehabilitation team. Instead of planning in terms of the immediate moment, the team plans in terms of the patient's life after recovery.

A roll call of the tuberculosis hospital rehabilitation team begins, of course, with the physician who is the captain of the team and whose authority is complete and final. The team

is composed entirely of trained hospital workers, and efforts to substitute untrained workers have produced some grotesque results.

To whatever degree the physician delegates some parts of the mechanics of intercommunication and record, the command of the team and the responsibility for its smooth performance are his alone. Such teams work most smoothly when the individual members can submerge anxieties regarding their own importance and security in the treatment of the patient.

I have already described the roles of the occupational therapist and the medical social worker in the program of the tuberculosis hospital rehabilitation team. The newest member of the team, chronologically, is the vocational counselor. In some hospitals, he is a regular member of the hospital staff; in others, he is on the payroll of the state vocational rehabilitation service. His initial function is to study the previous employment or non-employment of the patient, to interpret it to the physician in terms of its physical demands, tensions, and hazards. He is also equipped to assist physician and patient in future occupational planning, including training resources and placement opportunities. Without him, the team too often tends to encourage planning for obsolescent or diminishing employment channels. By utilizing the state's many industrial contacts for all types of disability, he can contribute a wider range of employment objectives than are otherwise known to the hospital group.

The occupational therapist can contribute to the vocational counseling function her observations of the patient's methods or lack of methods in the use of tools, materials, and instructions. She can administer mechanical try-out projects when medically prescribed, thus contributing substantially when patients have no previous employment history.

Other members of the rehabilitation team noted in some of our more progressive hospitals include public health nurses whose function is to orient each new patient and each new hospital employee regarding the general nature of tuberculosis, the methods of that particular hospital for treatment, phophylaxis, etc. When teachers, librarians, and other trained special workers are available, they also function as members of the rehabilitation team.

There is no stock blueprint for such programs. In each instance the routines have been planned by the medical director to meet the needs of his particular patient group and to utilize the resources of his particular hospital and its staff. The nearest approach to standardization is in the hospitals operated by the Veterans' Administration, and even in this agency the specific composition and methods of the rehabilitation team are variable at the discretion of the medical director.

Occupational therapists have complained at times that, while every graduate therapist is hospital-trained to work with physicians, almost no physicians are trained to prescribe the skills of occupational therapists. The tuberculosis rehabilitation team provides, for the physician, a continuous opportunity for the enlargement of his experience in the use of the specialized skills of other trained workers.

In tuberculosis rehabilitation, we are accustomed to utilize the statistics of the state vocational rehabilitation services as a barometer of progress. We are aware that some patients achieve rehabilitation without such assistance and that the figures are by no means inclusive. They do not include, for example, such service by the Veterans' Administration, by hospitals themselves, or by voluntary agencies. However, no other agencies yet provide figures comparable in uniformity, reliability, and completeness. Recording precisely the story of the official vocational segment of total rehabilitation, they supply signals of statewide progress, stagnation, or regression for total service for the patient group.

Look, then, at the figures provided by the Federal Office of Vocational Rehabilitation regarding vocational rehabilitation of the tuberculous, first for the country as a whole. In 1936-37, the states served 585 tuberculous clients; in 1946-47, they served 3,519. Surely there is still room for growth, but note the rate and direction of the upward curve. Progress can happen even more rapidly than that, as witness the increase in Michigan of service for 140 patients in 1943-44 and for 433 patients in 1947-48. This particular increase is attributable in considerable part to the introduction of team methods in the hospitals throughout the state, with the aid and coopera-

tion of the Michigan state vocational rehabilitation service.

We are accustomed to use as criteria of performance comparisons with the need for such services as indicated, generally by health statistics. Of these, the number of deaths is as yet the more reliable and the number of new reported cases the more popular. By such criteria, Connecticut led the states in 1946-47, serving 147 patients, as compared with 555 deaths and 1,044 new cases in the preceding year. Connecticut vocational rehabilitation workers are first to agree that this ratio can be still further improved.

Tuberculosis workers are unusually fortunate in that, much as we complain of flaws in our statistical reporting, we are nearer than workers in most disabilities to accurate and objective estimates of our needs for vocational rehabilitation service. It is no longer necessary to pull figures out of the air; the recorded experience of the states indicates what can be done with regular working contacts between the state services and the treatment facilities.

In conclusion, my suggestions regarding what therapists can do with and about such progress take this direction:

1. The American Occupational Therapy Association can continue its educational publicity to identify occupational therapy as an important process in total rehabilitation.
2. Schools can continue to orient students to the rehabilitation result possible in team performance which includes occupational therapy.
3. The Committee on Education of the American Occupational Therapy Association might induce the Committee on Education and Hospitals of the American Medical Association to give further consideration to the inclusion of medical curriculums of orientation for the medical student in the prescription and utilization of occupational therapy.
4. The association can join efforts with other professional societies to work with civil service commissions for improved recognition of educational preparation and professional skills in the entire range of supplementary medical services.
5. The individual therapist can make her own records less of a cashbook of supplies and more a chart of occupational data, noting and setting down on paper the modifications of use and habit in her patients.

Use of Occupational Therapy to Modify Significant Patterns of Personality Functioning in Desired Directions

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and
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The effectiveness of occupational therapy in rehabilitating persons disabled in various ways is increasingly recognized in medicine. With such recognition develops the need to describe more systematically (a) the patterns of difficult functioning which handicap patients and (b) practicable procedures of occupational therapy which result in more effective or less injurious patterns of functioning.

We have achieved reasonably useful descriptions of the way in which an amputee is handicapped, or a person with emphysema, scoliosis, arthritis, diverse injuries to nerve or muscle, etc., and we have achieved correspondingly useful procedures for maintaining or increasing such a person's effective functioning. Our achievements are not so satisfactory when we deal with the handicapping patterns of func-

tion of persons with behavior disorders; disturbances of intellectual, emotional and social (interpersonal) functioning. There are understandable reasons for our difficulties in this field of disability. There is not sufficient agreement among students of the subject concerning the nature of the difficulty from which the person suffers, the origin of his present difficulty, the number and types of factors causally relevant to his difficulty, the outlook for his improvement, the way in which he improves, or the effectiveness of various ways of helping him. In comparison with disabilities at the physiological level, the behavior disturbances are more complex and patients are less clearly aware of their nature; so that both therapist and patient find it harder to define what is wrong, to define what will be helpful, or to practice what will be helpful.

Granted these uncertainties, it is worthwhile to attempt some description of the difficulties manifested by persons with behavior disorders which (a) applies to most of them, (b) covers types of function significant for their disability and their rehabilitation, (c) remains within the area of agreement among students in the field and (d) permits application of helpful procedures by the occupational therapist.

We may start with the propositions that (1) persons with behavior disorders have difficulty in adjusting their activity to others' activity, (2) the most frequent and significant types of such maladjustment can be defined and (3) suitable occupational therapy can bring about improvement in the ability to adjust to others: the goal of rehabilitation being a personality able to adjust, with maintenance of stability, to a wider variety of conditions and people than was the case before therapy.

Some of the most frequent patterns of maladjustment found in persons with behavior disorder (no matter whether we speak of psychosis, psychoneurosis, psychosomatic disorder, etc.) are the following:

1. Inability to grade smoothly overt expressions of impulses to act. The most common examples are of persons who have frequent impulses to act, to talk, to assert themselves, to differ, to argue, to criticize, or to fight, but do not act upon such impulses overtly in a way which is also prompt, adequate, and appropriately directed. For various reasons having to do with their life experiences, they may accumulate such impulses over a period of time, only to explode violently over an admittedly trifling situation. The explosions may take the form of action against other persons, or animals, or of sudden changes in job or other important parts of the habitual pattern of living, or of diverse physiological, emotional, intellectural or social dysfunctions (diarrhea, headache; depression, anxiety; hypochondriacal fears, paranoid thinking; social withdrawal, delinquent acts). The explosions of overt action often occur at irrelevant times, are directed against the wrong persons, and are generally excessive in proportion to the external stimulus, as others see the entire situation. The complaints made by such persons, or by those in their social orbit who observe them, usually are limited to the unfortunate consequences of the explosions, but so long as the described pattern of frequent recurrent suppression of impulses to act persists, the explosions tend to persist too. So ingrained is the over-all pattern in many persons, that they cannot conceive of the high level of spontaneity, assertiveness, initiative, and leadership at which they could inherently have operated; yet until such an optimal level is maintained habitually, their behavior remains all-or-none, poorly graded, relatively inflexible.

With such persons, the occupational therapist's role can be to discover (a) solitary and interpersonal situations naturally bringing out frequent overt spontaneity, initiative, assertiveness, constructive give-and-take difference, leadership, (b) ways of combining such situations with the available activities in the occupational therapy shop. An activity can be selected in which the subject must act often; or must often start a process which others then carry on; or must often make a decision that part A of a process has been completed, and then start part B; or must direct assistants whom he needs.

One starts carefully, and observes the response of the subject to each procedure tried, until it seems clear that a stable mode of interpersonal action is being reached by the subject, at a level which both therapist and physician have judged, by such evidence as they have, to be more optimal for him.

Examples of available procedures which are helpful in relation to the above described type

of difficulty in personality functioning are: hard work (such as pounding sheet metal into shape), group outdoor gardening and painting furniture with at least one other person participating.

2. Difficulty in sustaining an action once started. Many persons put out effort initially at peak levels they do not sustain; hence they often build up expectations in their friends, superiors, etc., which cannot be fulfilled, and suffer serious recurrent frustrations in work, school, career, and interpersonal relations. Such behavior is often correlated with similar patterns in much simpler tasks, and appears to be modified in the patient's long-term interest, by suitable practice on activities requiring increasingly long sustained physiological and interpersonal activity.

The occupational therapist can attempt to discover such activities as require, both at physiological and interpersonal levels, sustained tempos within the capacity of the subject. By trial-and-error, the level of sustainable activity which is judged optimal for the subject is sought.

Examples of available procedures which are helpful in relation to the above described type of difficulty in personality functioning are: making a leather pocket comb and fingernail file case, followed by a leather bill fold, followed by a woman's leather purse; or making a small whatnot shelf of wood, followed by cream and sugar containers out of tin cans and sheeting, followed by a wide silver bracelet.

3. Tendency to concentrate upon too few persons in one's interpersonal relations. Many persons have difficulty in responding, in appropriately flexible ways, to more than a very few others; they tend to form all-absorbing affectional relationships with one or two people at a time, while having practically no warm feeling for any one else at that time. Should they lose one of these significant figures, by death, separation, jilting, quarrel, etc., they tend to suffer serious consequences which are often their present illness. Moreover, they find it extremely difficult to discover a suitable substitute; for the qualities necessary to find new friends, spontaneity, initiative, flexibility, are in them poorly developed; hence the behavior disorder tends to become fixed.

For a time, such a person may need intense frequent contact with one person, who may be the physician or other therapist. From the long-term view of diminishing his vulnerability to separation from a significant person in his life, he will benefit from activities designed to give him practice in dealing sustainedly with a number of persons who differ in age, sex, intelligence, background, energy, flexibility, etc., so that he can adopt a number of different roles in these different interpersonal relationships and find social satisfactions in more ways. Such practice may be combined with attempts to diversify the pattern of interests of the patient, as well, in that some of his associates will have hobbies or recreations new to him; and to increase the capacity to act responsibly towards a variety of persons.

Examples of available procedures which are helpful in relation to the above described type of difficulty in personality functioning are: making some object for a doctor or nurse; accepting a defined responsibility in the occupational therapy shop which involves dealing with other patients and with the occupational therapist, as making and serving mid-morning coffee for the group, acting as one of a group that cleans up mid-morning refreshment dishes, keeping in order a particular cabinet or section of the shop; graded participation in recreational activities, such as (in order) helping therapist prepare shop for party, getting food for the party, participating in group wrapping of prizes for party, assisting therapist in game group, pouring punch at party, serving punch, assisting in preparations for movies and special entertainments, assisting in clean-up after such special events.

The above suggestions are intended not to cover all the possibilities, but only to indicate an approach to the more effective use of occu-

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pational therapy for persons with behavior disorders. Similiar attempts have been made by others. Two which will well repay careful reading are those of Chapple[1] and of Davis[2]. The suggestions made here take it for granted that the occupational therapy procedures are part of a comprehensive therapeutic plan which includes competent intensive psychotherapy.

Peripheral Nerve Injuries Amenable to Occupational Therapy

By Lester Adran Mount, M.D.

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Essentially all injuries to peripheral nerves of the extremities are amenable to occupational therapy. The first step in therapy is evaluation of the disability. Loss of muscle power and sensation are, of course, the paramount problems but if the injury is long standing and mobilization has been impossible or neglected, articular limitation and even contractures may be present.

The principles of therapy are exercise of the muscles, keeping the joints flexible, the prevention of contractures, and the prevention of injury to anesthetic areas. Exercise increases the blood supply to the weak or paralyzed muscles, and prevents the ingrowth of the scar tissue which results in contractures. An increase in connective tissue is found in muscles three weeks after injury. The contraction and relaxation of the involved muscles as well as their antagonists tend to maintain muscle tone and to prevent atrophy. Over-stretching of weak muscles should be avoided. The joints should be kept flexible by repeatedly moving them through a full range of motion. Anesthetic areas should be identified and protected from injury.

Occupational therapy shoud be started as early as the surgical wound will permit. Before any muscle power has returned, passive or auxiliary exercises should be performed. An example of the former would be the use of a treadle to exercise the tibialis anticus muscle in common poroneal or sciatic nerve injuries. An example of auxiliary exercise is pulling the beater in weaving to exercise the biceps muscle in injuries of the musculocutaneous nerve. The biceps muscle is passively moved by contraction of the auxiliary brachioradialis muscle which assists in flexion of the elbow. When some contractures have taken place and no muscle power has yet returned passive stretching may be achieved as in molding or finger painting to stretch the flexor digitorum profundus and flexor digitorum sublimis muscles in radial nerve injury. These exercises passively relax the extensor digitorum and the extensor carpi radialis and extensor carpi ulnaris muscles and put the wrist and finger joints through a full range of motion. When voluntary contraction first appears in muscles, there will be insufficient power to move against gravity. Sling suspension may be used to overcome gravity. As strength increases gravity can be utilized. For example, using a vertical easel for painting in patients with deltoid paresis resulting from injury of the circumflex nerve. When strength has returned further the patient is able to work with various materials and apparatus. The force against which the patient works may be increased as the strength increases. An example of this is using a brake on a bicycle saw in patients with quadriceps femoris weakness due to injury of the femoral nerve, or changing from whittling soap to whittling wood in patients with median or ulnar nerve injury.

The psychological side of occupational therapy is important. The patient's interest must be aroused. This may be done by helping him select some worthwhile object to make which requires use of the weak muscles: a card table for a friend, a carpet for a bedroom, or a basket to use in his hobby of fishing. Sports also offer a valuable medium for treatment. Almost every

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Read at the 1948 Convention of the American Occupational Therapy Association.

patient is interested in some variety of sport.

The radial nerve is the one most frequently injured. When the injury occurs high in the arm, the patient will be unable to extend the arm at the elbow, wrist, or fingers at the metacarpophalangeal joints, and flexion at the elbow will be weak. In such cases over a year may pass before regeneration occurs in the most distal muscles. This means that passive or auxiliary exercises will be necessary for a prolonged period of time. Finger painting on both a horizontal and vertical easel, clay molding, rush plaiting, leather lacing, miniature golf, throwing and catching a ball may be used early. Gravity may be utilized to extend the elbow and wrist. In fact the grip will be better when the wrist is extended. Some variety of wood working such as planing, sanding or polishing may be accomplished early but later when voluntary extension of the elbow and wrist returns carpentry is more valuable. Then, too, more active sports such as ping pong, volley ball, handball, and tennis are possible.

The ulnar nerve is the next most frequently injured nerve. When this nerve is injured flexion at the wrist is weak, flexion of the 4th and 5th fingers is very weak, and extension of the 4th and 5th fingers and adduction of the thumb is impossible. In this case the sensory changes are important to recognize in order to prevent injury to the anesthetic little finger, ulnar one-half of the finger and the corresponding portions of the hand on both the palmar and dorsal surfaces as far proximal as the wrist. Clay modeling, ceramics, finger painting, leather lacing, basketry, polishing, sanding and other wood working may be performed early. Later printing, including typesetting and make-up, and then use of the hand press, weaving, all forms of carpentry, and various sports may be done.

In median injuries, the third most common nerve to be injured, the disability is greatest. When the injury occurs at or above the elbow, flexion of the wrist and ulnar three fingers is weak. Only the little finger can be completely flexed and the thumb and index fingers cannot be flexed at all. The thumb can be abducted weakly and adducted but opposition is impossible. There is anesthesia in the palmer surface of the thumb, index, and great fingers and in the radial one-half of the ring finger. The anesthesia extends to include the dorsal surface of the index and great fingers and the radial one-half of the ring finger. With such marked disability, both in the motor and sensory spheres, occupational therapy is necessarily limited until some motor power returns. Kneading and modeling of clay, whittling of soap or soft wood, basketry, or wood working may be accomplished early. The handles of the tools may be made larger by the use of dental compound. Thus they may be used more effectively. As muscle power returns the size of the handles may be reduced. Later screw driving, hammering, typesetting, printing with a hand press, weaving, typing, and leather work, particularly cutting and punching, but also tooling and lacing.

The sciatic nerve is the largest in the body and is the one most frequently injured in the lower extremity. Anatomically the sciatic nerve sends no branches to the hamstring muscles but the nerve to the hamstrings is frequently enclosed in the same sheath as the sciatic nerve and may be injured at the same time. If the nerve to the hamstrings is injured, flexion of the knee will be weak. Injury of the sciatic nerve results in a flail foot, there being no voluntary movement of the ankle, foot or toes. There is complete absence of sensation below the knee except for the anteriomedial surface of the leg which is supplied by the saphenous nerve. If the sciatic nerve is injured high in the thigh, eighteen months may be required for recovery to take place. Many different mediums of occupational therapy are adaptable both early and late. Most utilize foot propelled mechanical tools. Among these are the foot treadle saw, the bicycle saw, printing with a floor press, treadling a potter's wheel or treadling a sewing machine. Walking itself is a good exercise but the tibialis anticus muscle must be protected from over-stretching.

The femoral nerve is infrequently injured. A high injury of the femoral nerve results in inability to extend the knee and anesthesia in the anterior surface of the thigh and the anteriomedial surface of the leg. Here again occupational therapy is applicable both early and late. Leg propelled mechanical tools such as the bicycle saw, bicycle sander, treadling of various sorts, as mentioned above, rotating potter's wheel, and so forth.

It is clear that occupational therapy serves

many purposes. It is diversional and moral building. It is therapeutic in the maintenance of muscle tone and volume, in the strengthening of muscles, in the prevention of the limitation of movements of joints, and in the prevention of contractures. It is valuable in the training and strengthening of muscles to compensate for those whose function will never return. In addition, it is training for a new vocation or avocation.

Evaluating the Effectiveness of a Psychiatric Occupational Therapy Program

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Occupational therapy is assumed to be an extremely important part of treatment in psychiatric hospitals. To test this assumption we are presenting the methods of investigation used at the Boston Psychopathic Hospital, which methods, even considering the special problems of this hospital, seem generally applicable in the evaluation of occupational therapy. This presentation includes (1) methods of evaluation of the extent and manner in which the occupational therapy department serves the hospital, (2) discussion of the reasons for deficiencies in the program, (3) methods of studying the therapeutic effectiveness of the occupational therapist's work with the patient. Demonstrating the present effectiveness and the possibilities for improvement in occupational therapy is valuable not only to the occupational therapist but to the doctors, administrative officers, trustees and others with whom occupational therapy activities are integrated. As this is a broad subject many methods will be mentioned only briefly. Reference to our two previous papers [1, 2] on Boston Psychopathic Hospital Occupational Therapy Department in this Journal will clarify many points.

TOTAL HOSPITAL NEED

Almost all the patients of the hospital should be served by the occupational therapy department. Exclusion of any group is not justified except as an expedient. Even with patients for whom it may seem at first that little can be accomplished by occupational therapy, special research should be undertaken to determine whether occupational therapy has more to offer.

The patients shoud be served throughout the active part of the day and evening, those parts of the day that in normal life are expended in work or play. This amounts to approximately twelve hours a day, except for those patients (insulin and electric shock treated) part of whose day is occupied with receiving and recovering from treatments.

Table 1 shows the degree of occupational therapy coverage of patients' needs in terms of the extent to which patients receive a full day and evening program. Part of this total coverage is made by the nursing service and other workers.

Here it is seen that in a one hundred and twenty bed hospital with three trained therapists and one craft and recreational worker with the assistance of student and volunteer workers, there is over one-third deficiency in occupational therapy coverage measured by standards which are considered those of adequate rather than optimal coverage.

The authors are indebted to Adelaide Partridge, O.T.R., Dolores Zintz, O.T.R., Catherine Lambe, O.T.R., Anne C. Wood, O.T.R., Marion Plotnick, O.T.R., and Francis MacCumber of the Boston Psychopathic Hospital Occupational Therapy Department for compiling much of the data presented and they wish to express thanks for this assistance.

TABLE 1. EXTENT OF OCCUPATIONAL THERAPY COVERAGE OF PATIENTS' NEEDS

	Participants	*Total*
Number of patients to be served (number in hospital)		120
Number having full time programs in occupational therapy, crafts and recreation department	50	
Number having full time programs (industrial therapy) planned and organized by occupational therapy department — supervised by other departments	10	
Number having partial programs (45) Part of full day served (1/3) Equivalent complete programs (45 x 1/3 = 15)	15	
Total	75	120
% Coverage—63		

A further deficiency is not pointed out by this table—that of absence of occupational therapy periods throughout the weekends. This shows the therapist and anyone to whom she presents the data the proportion of patients that her program is reaching. It establishes a numerical standard against which she can check her progress from year to year. The number she should serve as against the number she does serve is a critical index of progress. Polonio [3] used a similar method in stating the number "occupied" with occupational therapy in his hospital and showed the enviable coverage of 93-100 per cent.

EVALUATING THE QUALITY OF THE OCCUPATIONAL THERAPY PROGRAM

The evaluation of the quality of the occupational therapy program is far more difficult than a quantitive evaluation of the proportion of patients served. It must necessarily be crude in that the optimum of patient satisfaction in good interpersonal relations and accomplishment is hard to appraise. It is, however, possible to determine such things as the number of patients who take pleasure and interest in a program as against those who participate either through the feeling of compulsion or simply to alleviate an hour of boredom. It is also possible to listen to what the patients have to say about the activities and judge from this what they want. The first step is the presentation of what activities are offered. Table 2 presents this data for Boston Psychopathic Hospital Occupational Therapy Department together with a list of desirable activities which are not generally available here.

The variety and effectiveness of the games used in the occupational therapy department and on the wards by the ward occupational therapist was sufficient to warrant description. Our study reported elsewhere [4] demonstrated their effectiveness in ward socialization. At all

TABLE 2. WHAT ACTIVITIES DOES THE PROGRAM OFFER*

Type of Patients	*Activities Offered*	*Activities Missing*
Acutely ill males	Games, leather work, reading, belt making, finger painting, clay work, artistic painting, furniture painting, copper tooling (available on the ward)	Carpentry, wood carving, typing, bingo, metal work
Acutely ill females	Sewing, needlework, games, leather work, finger painting, knitting, crocheting, spool weaving, clay work, artistic painting (available on the ward)	Group sewing projects, bingo, copper tooling, weaving on looms, typing
Convalescent patients, male and female	Painting, copper tooling, shell jewelry making, composition of hospital paper, weaving, needlework, sewing, games, dancing, singing, pottery work leather work, woodworking, finger painting, artistic painting, typing, mimeographing, furniture refinishing and repairing, making knotted belts, gardening (available in O.T. Department)	Model planes, model boats, cabinet making, plastic working, heavy metal work, radio making and repair, dress making

**Other activities: ward work, spontaneous activities are presented under separate headings.*

times playing cards, checkers, Chinese checkers and jig saw puzzles were available to the patients on all wards. A pingpong table was set up in the male acute ward and proved surprisingly useful. (It should be borne in mind throughout the article that our so-called acute wards contain not only acutely ill patients but also our new admissions and patients waiting transfer to the convalescent ward.) It attracted patients who were overactive and disturbing and even some particularly seclusive patients. When the table was taken away for repairs, its real effect as a socializing force was observed because of the marked increase in disturbing activity of some patients and at the same time the lapse back into apathy of others. The games which were introduced by the ward occupational therapist, or her assistants (students, volunteers, affiliate nurses and attendants) were table horse racing, table baseball, bingo (see Figure 3) and roulette. Bowling was introduced in the acute male ward with trepidation because balls and pins made such convenient weapons of aggression. Predictions of disaster were the rule, but, although first there was the utmost caution and watchfulness by personnel, within a week the most aggressive patients were rolling the balls along the linoleum of the back corridor against the pins set up in front of a mattress at the other end with scarcely a fearful thought from occupational therapist, attendant or nurse and in six months experience there have been no accidents. (It is interesting to speculate whether games involving violence do not permit release of aggressive impulses and so constitute an important part of therapy.) Non-equipment games such as charades, ward games, have been introduced effectively by the theological students but their continuance requires personnel skilled in their use. Pingpong tournaments have been shown to arouse interest in patients that the game alone did not arouse, but here also the organization required needs the attention of an additional worker. As a general principle the more highly organized the games are, the more socialization there is.

Ownership and Use of the Articles Made in the Occupational Therapy Department

The policy regarding the disposition of articles made in the occupational therapy department was considered extremely important. The products were the creations of the patient made with material either purchased for therapy by the Commonwealth or from the donations of friends of the hospital and so properly belonged to him. In this way it was felt that he could get the greatest satisfaction out of his accomplishment which in itself was considered an important part of therapy. The patient could do what he liked with the product. About 80 per cent of the products were kept by the patients, usually to be given to relatives or friends while the patient was still in the hospital. Occasionally the gift was given to the patient's doctor. Many examples were seen wherein the patient's creation used by him as a gift served to improve his self-esteem and his social relationships and presumably aided in his recovery. It was difficult to get enough articles for display in the department from those that the patients did not care to keep in that only about 20 per cent preferred to make things for the hospital. When articles were made for the hospital an effort was made to display them in a way that would gain the appreciation of other patients and personnel. For example, a patient who painted pictures usually placed some on the wall in his ward. During this study it was found that this policy has not been followed with woven rugs which have not gone to the patient's ward as would have been preferable.

Ward Work

Ward work is carried on by the nursing service, the nurses and attendants on the acute wards directing the patients whom they feel will benefit by it. On the convalescent wards work is arranged by a patients' government committee on a cooperative basis. This provides constructive work for two hours of the patient's day. The work includes not only cleaning, bed making, food serving, dish washing but, in addition, furniture and room painting, radio repairing, rearrangement of furniture, sorting books and magazines, assisting in the care of bed patients.

Industrial Therapy

Industrial therapy is limited to work in the kitchen (2-4 patients), in the biochemical laboratory (1-3 patients), in work with the gardener (2-3 patients), in typing (2 patients) and secretarial work (1 patient). Although

TABLE 3. PATIENTS' EVENING PROGRAMS

Day	*Type*	*Directed By, Assisted By*
Monday	Bingo and community sing	O.T.R., assisted by Theological student
Tuesday	Talent night, a community sing with dancing	Gray Ladies, affiliate nurses, attendants
Wednesday	Psycho pops	Graduate student in Music, Ph.D. thesis candidate. Patients' committee
Thursday	Patients' dance	O.T.R., assisted by nurses and attendants
Friday	Special movies, or open night for miscellaneous events	Ladies' Auxiliary, affiliate nurses or Patients' Government
Saturday	Coffee hour, dancing, refreshments	Patients' Government committee assisted by attendants
Sunday	Movies	Supervisor. Pictures selected by hospital librarian and Patients' Government committee.

there are fewer industrial projects available than in a hospital which receives more long-term patients, yet even here there are far more industrial opportunities than we have been using. Additional skilled personnel is needed to work out with the patient's physician and with the personnel of other departments the details of individual industrial placement.

Special Projects

Special projects include writing and compiling the hospital paper, serving on committees for arranging musical evenings, planning coffee hour, patients' government and patients' theatrical performances. The supervision of these projects except for that of the hospital paper is largely by the nursing service.

Spontaneous Activities

Much of the most valuable activity is that which occurs spontaneously on the wards, fostered by a stimulating ward atmosphere which encourages creativity—e.g., a patient pianist and a banjo player may give daily accompaniment to community singing on a convalescent ward. At other times an attendant on an acute ward may, with patient leaders, bring about a community sing. Patients may start pingpong tournaments and enlist the help of attendants as referees. A letter to the editor in The Psychiatric Aid [5] tells of one such activity.

Evening Programs

Evening programs take place seven evenings a week as outlined in Table 3 and are attended by more than half the patients in the hospital. All convalescent patients may attend these programs and those from the acute wards who have their doctor's permission. One special development is the inclusion of patients' relatives, patients at home on visit, and selected out patients.

One of the considerations in evaluating a program is whether or not it occurs with optimal frequency. Also the program should be meaningful to the patient, and the opportunity should be available frequently enough so that it is a consistent and important experience to him. Table 4 offers a further check on the hospital occupational therapy activities in that it presents a list of special programs with their frequencies as against the frequencies considered desirable. The desirable frequency of any program is the estimate of the occupational therapists based on (a) the requests made by patients, (b) experience with programs, the frequencies of which were decreased because of insufficient personnel, (c) on general community experience with frequency of gatherings. Those activities which have been tried but have not been continued for lack of personnel are not included in the table.

That patients have programs available every evening in the week is, of course, important to their living a wholesome life in the hospital even though it demands a great amount of effort on the part of the occupational therapy and nursing departments and volunteer and student groups. The dramatic club functions because of the interest of two attendants, two affiliate nurses and a volunteer actress. The pottery class is a project of the Ladies' Auxiliary. The need for student and volunteer help to carry on adequate programs is apparent.

Table 5 presents the proportion of patients for whom special programs are indicated and those who are actually participating in such programs. Here again the number of patients who should receive a certain program is an estimate made by the occupational therapists

TABLE 4. QUALITY OF O.T. AVAILABLE, PRESENCE AND FREQUENCY

	Optimal hrs. per week	*Actual hrs. per week*	*% effective*
Evening programs available	14	14	100
Choice of evening programs	14	1	7
Patient participation, evening programs	8	4	50
Book club	2	0	0
Dramatic Club	4	4	100
Educational classes, scholastic	4	0	0
Cooking, dress making	3	0	0
Bird walks and other out-of-doors organized nature study	4	0	0
Pottery class	6	6	100
Dancing class (instruction)	4	0	0
Patient Government meetings	2	1	50
Beach parties and trips	2*	1**	50

*Four-hour trip every other week

**Four-hour trip monthly

on the basis of group discussion which considered the patients' social and educational background and a theoretical evaluation of their therapeutic needs and their requests.

TABLE 5. QUALITY OF O.T. AVAILABLE, PROPORTION PATIENTS SERVED ADEQUATELY

	No. Pts. for whom indicated	*No. participating*	*% receiving*
Creative occupational therapy work adapted specifically to to patients' ability and needs	80	20	25
Recreation and hobby activity adapted specifically to patients' needs	100	40	40
Varied evening entertainment daily	100	50	50
Out-of-doors walks, sports, and games in clement weather	80	60	75
Prevocational progressive educational classes adapted to patients' needs	18	3	17
Clubs: book, dramatic, etc.	60	10	17
Patient government groups effective in ward socialization	60	60	100

Although we have shown that the majority of the patients in the hospital are served throughout the day and evening by the occupational therapy program, yet here we see that there is a deficiency in the quality of the program in that there is insufficient creative work, recreation, hobby, club and prevocational work specifically meeting the patients' needs. It is generally known that programs of this type require more personnel than are available here. Out-of-door walks was rated 75 per cent and this degree of completeness is the result of the cooperative effort of nursing staff, occupational therapy and physical therapy. More careful consideration of out-of-doors walks shows that there is room for much improvement. The walks are limited to the hospital grounds and would be more stimulating if they included many of the pleasant parks off the hospital grounds. Patient government has been so successful that it is self-perpetuating by the patients themselves and constitutes what is becoming the most important organization for improved hospital living, further supporting the contention that the best occupational therapy programs require the development of patient leaders. The promotion and implementation of the patients own spontaneous creativeness and social ability is an integral part of any therapeutic process.

Critiques of the Program

Much of the occupational therapy is on solitary projects of one patient working alone with material that offers little experience in cooperative work and group socialization. Solitary projects do have a place in an occupational therapy program in that they furnish a relief from boredom and give training in concentration and craftsmanship but they do not fill what we consider the prime function of a psychiatric occupational therapy program, that of stimulating the social interest of the patient, of improving the patient's adjustment to others in such a way that it will lead to social rehabilitation outside the hospital. There are no group sewing or carpentry projects and few team games. Clubs are notably deficient, only serving

17 per cent of those for whom they are indicated. The only substantial work group is that of 2-3 patients who do hospital painting, working together in the same room.

The deficiency of suitable craft work for men, such as carpentry and cabinet making, is a real lack. Industrial therapy facilities are so limited that patients who have been in the hospital over three months complain that they have done everything. More personnel for adequate examination of the abilities of patients and for interdepartmental integration are needed to take advantage of the unused opportunities for industrial therapy.

Although several of the evening programs are participant events, too many fail to give the patient opportunity for personal participation. Many evening programs also fail to include activities which are part of the normal cultural background of many of the patients. For example, although the dance night provides a customary and enjoyable entertainment for most of the patients, yet it offers little to many of the older men and women present who are no longer willing or interested in participating and it accentuates the difficulties of those young patients who do not know how to dance. Part of this difficulty has been solved by the suggestion of the patient's government that bridge tables be set up during dances. In some cases we have found special teaching of dancing an important socializing influence but have been able to do it only when skilled volunteer workers were available.

Choice of evening activities is not offered except during part of one evening (Monday). Not only is the process of selection of an activity an important experience for the patient but choice gives the patient the sense of freedom and furnishes programs more specifically adapted to the patient's needs.

Quality of the Program Measured by Extent to Which It Meets the Special Needs of the Patients

Critical periods in the patients' hospital life require special applications of the occupational therapist's skill. The most effective time of therapy should occur on the first days the patient is in the hospital, when the patient is transferred from one ward to another, and after the patient leaves the hospital. The patient's admission to the hospital represents a crucial experience. Making a new community adjustment is a hazard to any one and much more so to the ill. The occupational therapist has an opportunity to bring about an important social relationship, to make the patient feel at home in a strange environment and offer something creative to do in that environment. Unfortunately this is an opportunity that is usually overlooked. This need is, no doubt, as great in the general hospital and other specialized types of hospitals as it is in a psychiatric institution.

TABLE 6. IMPORTANT PERIODS IN PATIENTS' HOSPITAL LIFE ON WHICH THE O.T. DEPARTMENT SHOULD CONCENTRATE

	O.T. Attention		
	Adequate	*Partial*	*None*
1. Introduction to the hospital community (introduction to the therapist and to O.T. opportunities)	X		
2. Primary granting of privileges (patient can be encouraged to bring in his own musical instruments, hobbies, etc.)		X	
3. Permission for off-the-ward O.T. and recreational activities (ward O.T. assists at bringing this about at the appropriate time and making a stimulating introduction to off-the-ward O.T.		X	
4. Special crises and disturbances (O.T. should be called to assist with nursing problems)		X	
5. The patient is transferred to a different ward. (Continuity of work and recreational interest helps bridge the gap which occurs as a result of ward change.)	X		
6. The patient leaves the hospital for short absences (and can be helped relate his hospital to his home experiences.)			X
7. The patient leaves the hospital. (Opportunities and arrangements for return to special events and continued O.T. work until he is employed.)		X	
8. The patient comes to the hospital for out patient treatment. (O.T. is particularly needed for out patients.)		X	

The patient who leaves the hospital, especially after a long hospitalization, has another major adjustment to make. It takes time to make new friendships, to renew old ones, to find welcoming work and play activity. Often return to the social functions of the occupational therapy department bridges the gap in a way that may prevent a relapse.

Table 6 is presented to outline some of the important periods in the patient's hospital life, and to indicate the attention of the occupational therapy department given to each of these periods.

The importance of each of these periods in the patients' hospital life is evident to anyone working closely with the patient from the time he is admitted until he is socially self-sufficient. The occupational therapist might feel that one of these periods is the full responsibility of some other department and thereby lose the opportunity of being of the greatest service to the patient. Here we have the responsibility of more than one department wherein optimal assistance to the patient requires close integration among the departments concerned. For example, the social service department might arrange for the patient's departure and guide his activities after leaving the hospital which requires close assistance from the occupational therapy department. The patient who is a ward nursing problem because of disturbing behavior is also an acute occupational therapy problem which may be alleviated if both nurse and occupational therapist recognize the way they can work together. The therapist can here demonstrate her ability in putting the patient at ease by furnishing the skill and materials which will interest the disturbing patient and provide outlets for energy.

Reviewing the above chart it is seen that only in the introductory period and in the period of transfer from ward to ward is the occupational therapy coverage considered reasonably adequate. The first was covered because the ward occupational therapist whose entire time was spent on the admission wards recognized the value of occupational therapy to newly admitted patients. Continued activity on transfer came about because the patients were sent early to the occupational therapy department through the combined efforts of ward occupational therapist, nurse and doctor and their transfer to a convalescent ward needed no further prescription. The major defect was failure to provide for the period when the patient started to go home on absences. Adequate attention to our patients and patients who are home on visit but not yet well enough to go to work requires additional therapists. The time study (Table 8) and present load on the occupational therapy department (Tables 4 and 5) shows that the present therapists can give an adequate program to only a few out patients without jeopardizing the care of in patients.

Subjective Attitude of Patients Toward Program

One of the most direct methods of evaluating a program is from asking the patients themselves what they think of it. After all, the patient knows what he really enjoys, he knows what relationships he has found most gratifying. A survey of patient attitude cannot be made by the occupational therapist herself. The patient is polite enough not to want to hurt the therapist's feelings. Here the therapist can enlist the help of someone else. Both psychiatric social workers and psychologists are trained in making such a study.

At this hospital a study was made by Mrs. Emily Hatch of Simmons College School of Social Work for the partial fulfillment of the requirements for Master's Degree in social work[6] with the following findings:

TABLE 7. HOSPITAL PROGRAM EVALUATED BY SOCIAL WORKER'S INTERVIEW WITH 100 PATIENTS[6]

	No. Pts.
Stated complete approval of hospital program	24
Neutral comments, such as "all right, no complaint"	26
Mixed attitude, expressed both favorable and unfavorable comments, made constructive suggestions for improvement	41
Negative comments, did not like the program	9
Total	100

The negative responses were mostly from male patients whose chief complaints were the lack of physical activity, fresh air, movies to their liking, and the use of the record player as often as the female patients.

There was general approval of the dance, evening games, entertainment, music of all kinds, and the efforts of the occupational therapists.

There was general agreement that week-ends were very depressive, "like a morgue," "nothing to do." Opening the doors between the convalescent wards, letting the patients into the game room had helped the week-ends a great deal.

Pingpong and roller skating were the most popular activities. Several asked for more bridge games, more cigarette prizes for games, a gymnasium and a bowling alley.

To furnish a continuous appraisal of her work the therapist can interview frequently the relatively unbiased professional persons who are having close contact with the patients—ward nurses, attendant nurses, doctors. These people are hearing daily what the patients say spontaneously about their different activities. They hear the patient say he doesn't like to go to the occupational therapy department and state the reasons why. In this way the therapist can keep in constant touch with unbiased appraisals of her program.

An example of this was furnished by Dr. Leslie, Protestant Chaplain of the hospital, who during a group therapy session, received the complaint from several patients that they did not have a free evening to do with as they wished. Since the employees on the convalescent wards helped with the evening programs, the patients had to attend them or go down to stay on the acute wards. This furnished further evidence of the need of choice of entertainment and of the fact that anything which seems compulsory is apt to disgruntle people even when desirable.

The therapist too often feels that she has "something to sell" rather than that she has something to learn. She feels she must influence and propagandize the other professional persons with whom she works. Instead they can be a constant source of information on the effectiveness of her program. They can teach her the places in which it falls short of meeting the need. This social interchange makes doctor and nurse think about the program in an orderly way and is perhaps the most effective method of bringing doctor, nurse and therapist to the fullest realization of the importance of any occupational therapy activity. It can be remembered that overselling is often based on insecurity.

Why the Program Fails to Meet the Patient Need

1. The Therapist Herself

A time study by each worker in the occupational therapy department kept daily for a typical week is enlightening as to how each worker spends her time. From this it is easy to make general appraisals of the worker's effective use of her time. Table 8 shows how much time is consumed with keeping records, ordering and caring for supplies and preparing material; how much time is spent with patients, either working individually with the very ill (column 4), training others (personnel, patient leaders, volunteers) to work with patients through actual clinical demonstration (column 3), supervising patient groups and activities (column 5). It also shows how much time is spent integrating activities with other departments and in educational classes for others and for herself.

Table 8 is a summary of the time study made at Boston Psychopathic Hospital. Here it can

TABLE 8. HOW THE O.T. SPENDS HER DAY. AVERAGE HOURS PER DAY AT EACH ACTIVITY

Working with Patients

Worker	*Conf. with doctor and nurse*	*Record keeping*	*Clinical Demon.*	*Individ. work with sicker patients*	*Supvs.*	*Teaching Lectures, seminars for others*	*Educ. self*	*Integration with other dept.*	*Prep. materials*	*Research*
Head O.T.	2/3	1/3	2	0	1	1	1	1	1	0
Shop	1/2	1/3	3	1	2/3	1/2	1	0	1/2	1/2
Craft & Rec.	1/2	0	1½	1	1	0	1	2	1	0
Ward	1*	1/2	2	1	1/2	1/2	1	0	1/2	1

**Ward rounds*

be quickly seen that each worker spends a little less than half the day with patients and that most of this time is utilized in training others to work with patients. The head worker spends a greater part of the day than the others in conference, integrating and supervising activities. Assistants spend almost an hour daily in conferring with doctors and nurses about patients' needs and accomplishments, showing the teamwork nature of their professional relations. The ward occupational therapist spends the longest with doctors and nurses, as it should be, for it is she who makes the first contact with the patient and institutes the first program for the patient. She can relay information to the other therapists when the patient progresses to the regular program. About an hour a day is spent in working relations with other departments. Although this time can be classified as administrative, it serves the additional function of bringing about constantly improving understanding with other hospital departments.

Only the ward occupational therapist had as much as an hour a day for research, which was spent in evaluating a program for lobotomy patients.

It should be noted that little time is available for research even though the occupational therapist should take an important place in the research of the hospital. The importance of research in occupational therapy has been emphasized elsewhere [7, 8]. The department can be thought of as a testing laboratory wherein the patient is introduced to a variety of occupational therapy and recreational activities and the patients' reaction to these activities carefully observed and recorded. The therapist's observations are of use in a variety of studies of diagnosis, prognosis and treatment response. (Note example of evaluation of lobotomy results, Chart 1 of this paper.)

From the time study the therapist becomes aware of the exact use she makes of her time. This portrayal of the workday can be shown to the medical and administrative staff to obtain their suggestions as to whether the allotment of time is most adapted to patient needs. It also gives a clear demonstration which is important in outlining further personnel needs.

2. Failure to Utilize the Help of Other Departments and Personnel of the Hospital is Perhaps the Most Impressive Weakness in Most Programs.

Already there has been reference to several activities which were particularly complete and effective because of the work of affiliate nurses, attendants, ladies' auxiliary, etc., as exemplified by the pottery shop and the drama program. Table 9 is an analysis of the degree of participation of different hospital personnel in the program of the occupational therapy department. This portrays the extent to which the therapist accepts and enlists the assistance of others rather than trying to do everything herself.

The extent to which other personnel, students, patients and volunteers are utilized is one of the indices of the efficiency of the occupational therapy department. The fact that there are few occupational therapists in any hospital necessitates maximal utilization and training of other persons to help them. Through the choice of those activities which the patients can organize themselves or which can be organized by non occupational therapists. It is improbable that there will ever be enough professionally trained therapists to meet the need for them. This need must be met by teaching and delegating responsibility and work to others.

Such training has the additional advantage of bringing about a broader knowledge and respect for occupational therapy by related departments, of furnishing advanced assignments which are particularly needed by patients with leadership ability, and of disseminating enlightenment to volunteer student workers about the mentally ill and what can be done for them.

Need for more personnel is a poor excuse for deficiencies in an occupational therapy program when there is little effective work being done by volunteers, students, patients, nurses and attendants. However, when it can be shown that the therapist is spending a large part of her time in training others to help her, and there are available other willing workers whose only need is training, then she has one of the best grounds for asking for more trained occupational therapists. In the time study it is seen that a half or more of the time of each of the occupational therapists is spent either directly or indirectly in training others who can be of assistance.

TABLE 9. PERSONS WORKING WITH PATIENTS IN O.T. ACTIVITIES—SECTION OF TYPICAL DAY

Place	*Hrs. per day*	*Persons assisting O.T.'s in supervising or teaching*					
		*O.T.***	*Attendants*	*Nurses*	*Students*	*Volunteers*	*Patients*
Ward							
Ward work on acute wards	2	0	2	1	0	0	0
Convalescent	2	0	1	0	0	0	3
Ward O.T.	2	½*	1	1	1	0	1
O.T. Dept.							
Workshop	4	1	0	(1 or 1)		0	1
Textile Room	4	0	0	1	(1 or 1)		1
Recrea. Room	4	0	1	1	1	1	1
Out of Doors	**	3	2	3	0	0	3

*Ward occupational therapist spends half time on each of two acute wards.

**Depending on the weather 0-4 hours.

***Head occupational therapist and recreational and craft worker do not appear in this study as they are located in no specific rooms and their duties call for them to spread their activities.

Table 3 showed that occupational therapists were present directing the evening activity on only two nights out of seven. The remainder were directed by other personnel, volunteers and by the patient leaders, clear evidence of the extent to which assistance must be enlisted from non occupational therapy personnel to give a full hospital program. It also shows the diversification of the assistants at evening activities; a situation that can come about only through effective utilization of resources outside the occupational therapy department.

3. Incomplete Utilization of Space Within Department and Within Hospital.

Good work depends on convenient geographical arrangement. Diagrams of the floor plans of the department which include the location and purpose of all work tables, cabinets, benches, etc., present the setting in which the usual number of patients about each activity can be inserted diagramatically together with the flow of patients from place to place within the department. Such a picture may best be obtained from actual observations.

That actual observations are strikingly successful in correcting a false impression held by an administrative officer may be illustrated by the following example. The administrator believed that the occupational therapy assistant in the workshop was working with too few patients; the observation (March 12, 1947) showed that her work was in direct competition with more attractive activities in the recreation room, the library and the textile room where, because of the large number of volunteer workers, the patients could get more individual attention.

There obviously should be a trained person to direct each room in the department but too few trained therapists are available. They can, however, direct the activities of less skilled room leaders. In a craft room the person need have only good craft training and ability to work with patients; similarly in the recreation room the person should be experienced in directing recreation. It is impossible for the same therapist to be efficient in directing work in two rooms at once. Time is wasted in trotting back and forth and neither room is directed adequately.

When there is an effective program of ward occupational therapy, the entire hospital becomes occupational therapy space. Polonio tells of this in his hospital[3]. Each ward can have its own supplies to be used under the direction of the ward therapist and head nurses. Much of the ward occupational therapy activities can be decoration and improving the ward surroundings. For example, the head nurse of one of the acute wards of Boston Psychopathic Hospital together with a talented affiliate nurse, with the help of the occupational therapy department, organized a patient painting team, painted their smoking room, smothed and painted the surface of their pingpong table, rebuilt a bookcase and painted decorative murals on the wall.

Later they turned the room into a dormitory and turned the previous dormitory which was more spacious and better lighted into a smoking room. Here patients had the direct benefit of their occupational therapy endeavors in creating for themselves more attractive living quarters.

Further Methods of Evaluating the Effectiveness of Occupational Therapy

It is difficult to show the effectiveness of any one form of therapy upon patients who are receiving other therapies at the same time. Because of our firm belief in the practical value of occupational therapy to patients regardless of its therapeutic value, it is impossible to set up an ideally controlled experiment wherein matched groups of patients are given occupational therapy and withheld from occupational therapy. Fortunately there are other methods available to determine the therapeutic effectiveness of occupational therapy. Short sections of a patient's social behavior may be studied, e.g., one hour with the next hour, and show changes from occupational therapy which could not well be attributed to other treatments. The carry over of improved behavior from the occupational therapy period into the post period interval would be further evidence of therapeutic effect.

Occupational therapy effectiveness may also be demonstrated by the new social skills acquired by the patients. Here, even if it cannot be shown that the ego support furnished by the new social skill directly influenced recovery, it may be granted that it so broadens the patient's ability to adjust that recurrence of the disorder may be less likely. Furthermore the usefulness of this new social or vocational skill in the patient's post-hospital adjustment can be determined with follow-up studies. Examples are appearing frequently wherein the patient has utilized skills taught in occupational therapy in his post-hospital adjustment—among these are: dancing, cafeteria work, laboratory work, secretarial work, literary interest, picture painting.

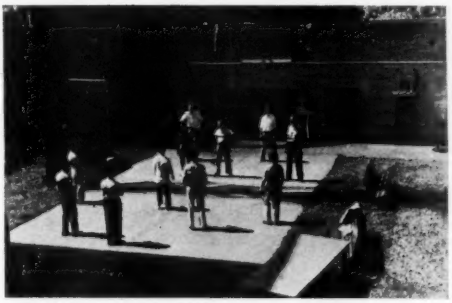
A criteria of improvement and relapse is that furnished by the changes in skill of workmanship and quality of the product produced by the patient. Here at least is, if properly evaluated, a concrete example of change in concentration, coordination, imagination, energy, etc.

Corroborative evidence concerning the effectiveness of occupational therapy is found in the occasions [3] where a newly introduced occupational therapy program at a hospital with few other changes in therapy brought about improved ward social life demonstrated concretely by the decreased restraint, seclusion and sedation.

The therapist, the patient and the project with which they work form a complex situation from which it is impossible to extract one unit without consideration of the others, yet for descriptive sake we try to identify the important attributes of each. The therapist has a certain individual personality, training and attitude; the patient has his complex background, personality structure, abilities and interests; the project has its own special qualities such as complexity, uniqueness, beauty. All these must be studied and understood.

Clinical Demonstration

Case presentation is a simple, clear method of evaluating and demonstrating the effectiveness of occupational therapy. Here a case is selected with which the therapist has worked intensively, wherein much is understood about the patient's background and problem. A detailed history of the patient's development, particularly in the areas of work and play is obtained. The therapist has carried on an organized program specifically adapted to meeting the patient's needs and at this time explains what has been done, what the rationale of the therapy was, and what progress was made in each step of the program. The other staff members (doctors, nurses, etc.) evaluate the therapist's effectiveness from their own point of view in the light of their own experience with the patient. In this way the subjective appraisal by the therapist of her accomplishment becomes subjected to the scrutiny and evaluation of others. Although it must be acknowledged that this method may be a composite of the biases of the various professional persons, it is one of the more reliable possibilities in evaluation. These case presentations not only serve the purpose of evaluating the effectiveness of occupational therapy but when accumulated in recorded or written form become source ma-



terial of further research and teaching. Examples can thus be accumulated of the therapist's success or failure in dealing with different problems in different ways.

Sociometric Methods

There are a variety of methods of observing and recording social behavior which are useful in demonstrating: (1) the methods of the therapist; concrete observations of the therapist's interpersonal relations with a patient or a group of patients, thus showing how the therapist responds to the patients. (2) Change in the patient's behavior in response to the therapist. This can be observed intensively over short periods of time such as before, during and after the introduction of occupational therapy activities. Serial studies made over a longer period of time show changes in the patient's condition which can be correlated with the type of therapy the patient was receiving at the time. (3) The activity itself can be studied to determine how many patients respond to it favorably. (4) Patients and personnel can be studied as a social group and their varying group relationships portrayed and analyzed.

Our technique, the sociogram portrayal of a time study of group interaction has been presented elsewhere[9] and the method and example showing the effectiveness of an occupational therapist in an acute ward is abstracted in this journal. *(See pg. 000—Ed.)*

Another technique, that of the use of activity participation charts as applied to ward occupational therapy, was described in a previous issue of this journal[1]. Briefly this method showed the gross levels of participation of all individuals, their response to the therapist, to other personnel and to the different activities. It shows the number of patients with whom the therapist works effectively.

In another article[4] we analyzed data obtained by these methods and arrived at generalizations relating to the use and effectiveness of games in ward socialization.

To exemplify further modifications and adaptations of these methods which are useful in occupational therapy, the following examples are presented. They were chosen because the same patient was included in the different types of observations.

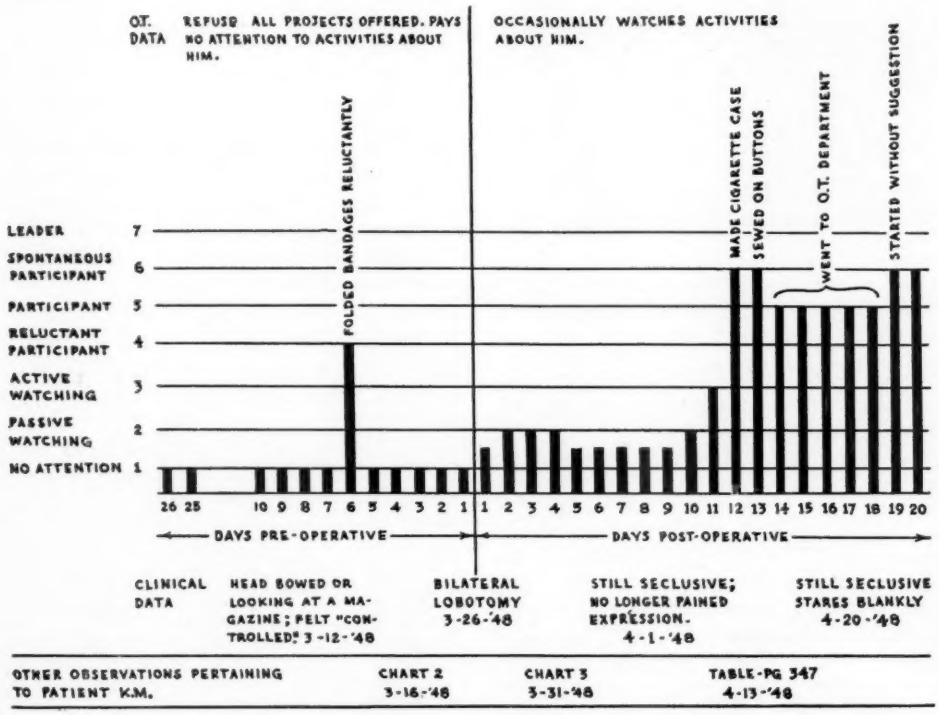
1. Serial Observations of Patient's O.T. Participation Before and After Lobotomy Operation.

After one hospitalization in March, 1947, when he was given two series of electric shock therapy without improvement, Patient K. M., twenty-three-year-old white male with a diagnosis of Dementia Praecox-Catatonic was admitted to Boston Psychopathic Hospital March 1, 1948, with symptoms of seclusiveness, restlessness, and resistive and impulsive behavior. He had left the second year of high school and never held a steady job, had rarely left the house and avoided visitors. Lobotomy was performed 25 days after admission, on March 26, 1948. He was transferred to another hospital twenty days later with condition described, "Continued mute and seclusive but no longer appeared tense; condition unimproved."

Throughout the period of his hospitalization at Boston Psychopathic Hospital he was included in the program by the ward occupational therapist and for the last eight days participated in the program of the occupational therapy department. The following chart supplies a synopsis of occupational therapy data, a portrayal of the patient's level of participation as observed by the occupational therapist on each day.

Chart 1 (page 344) presents the more important features of the occupational therapy data on the patient; the acceptance and refusal of different projects. Clinical data presented at the bottom gives opportunity for comparison of how occupational therapy activity may or may not parallel the other changes in the clinical picture. The use of these seven gradations of "levels of participation" furnishes an easily interpreted graphic presentation which highlights change more than a verbal description. The gradations used are easy to identify and require

CHART I PATIENT K.M. ACTIVITY PARTICIPATION CHART - PRE AND POST LOBOTOMY



MALE ACUTE WARD SMOKING ROOM—March 16, 3:07-3:22 p.m.

SOCIOGRAM, FOCUSED ON O.T. ACTIVITY

Diagnostic Description of Participants by Number

1. Dementia Praecox-Paranoid Type with grandiose religious and political delusions, aged 60.
2. Psychoneurosis-Psychasthenia; obsessed with fear of death by suffocation, aged 33.
3. *Patient K. M.,* Dementia Praecox-Catatonic Type; confused, disturbed, resistive and seclusive, aged 24.
4. Dementia Praecox-Paranoid Type; delusions of hidden microphones and syphilophobia, aged 30.
5. Psychosis with Organic Changes of the Nervous System-Presenile Arteriosclerosis; impulsive behavior, borderline intelligence, aged 51.
6. Dementia Praecox-Hebephrenic Type; preoccupied with homosexuality, silly, smiling and leering, aged 33.
7. Psychosis with Cerebral Embolism also Chronic Alcoholism; aged 60.
8. Undiagnosed Psychosis; alcoholic, neurotic, with depression, anxiety, and lack of confidence, aged 26.
9. Manic Depressive Psychosis-Hypomanic State with mood swings from grandiose euphoria with facetiousness and aggressiveness to depression, aged 20.

O.T.—MRS. ANNE C. WOOD, O.T.R.

O—OBSERVER, JUDSON HOWARD

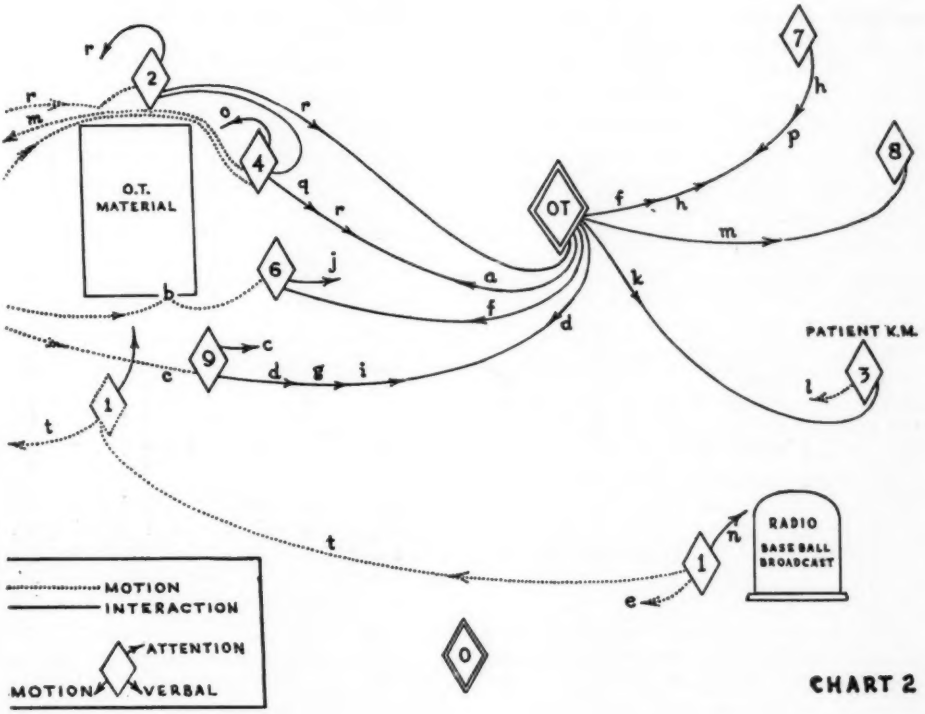


CHART 2

DESCRIPTION OF ACTIVITY IN SEQUENCE

a. O.T. speaks to Pt. 4 about ball game (broadcast).
b. Pt. 6 comes in, picks up O.T. material from table, takes it to bench and lies down.
c. Pt. 9 comes in and picks up a magazine.
d. O.T. and Pt. 9 talk together.
e. Pt. 1 sitting by the radio, piles checkers absently.
f. O.T. speaks to Pt. 6, then to Pt. 7.
g. Pt. 9 speaks to O.T., after finding out her name from observer.
h. O.T. speaks to Pt. 7 and they talk together.
i. Pt. 9 interrupts their conversation
j. Pt. 6 says, "Oh my" while working on leather project.
k. O.T. speaks to Pt. 3 (K.M.) asking him if he won't try some of the projects. Pt. 3 doesn't want to and stirs a little.
l. Pt. 3 (K.M.) turns over on stomach, head in hands and face to the wall.
m. O. T. talks to Pt. 8 who says he has a headache and rubs his neck. Pt. 4 goes out.
n. A commercial interrupts the ball game. Pt. 1 raises his head and smiles to himself. The game broadcast resumes and he seems to attend again.
o. Pt. 4 comes in and looks at O.T. material.
p. Pt. 7 talks to O.T. explaining that he can't work without his glasses. O.T. promises to look into his getting them, and starts out.
q. O.T. is stopped by Pt. 4 to talk.
r. Pt. 2 walks over to O.T. material, watches O.T. and Pt. 4 converse, picks up a ball, speaks to Pt. 4, and bounces ball. The three talk together.
s. Pt. 4 cuts leather on the table.
t. Pt. 1 gets up, walks to table with O.T. material, looks at material, goes out.

no further definition here except that number 4, reluctant participant, is one who requires skilled introduction to engage in an activity whereas number 5, participant (requires prompting), is one who is responsive to simple suggestion.

2. Focused Sociogram Ten Days Before Lobotomy.

On several days pre and post lobotomy observations were made according to the technique described elsewhere[9]. Here is presented Chart 2, a focused sociogram (focused on occupational therapist), omitting the interactions not directly related to the therapist and her materials. This observational technique served as a method of focusing on the methods the therapist uses, on her responses to the patients.

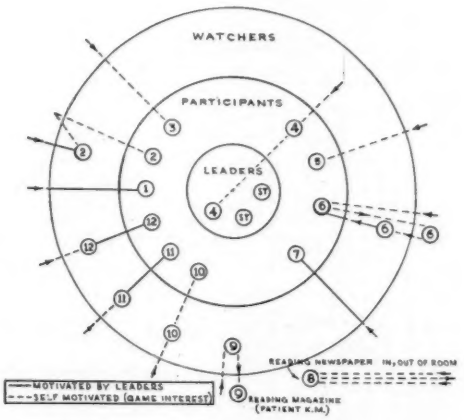
This observation made on Patient K. M.'s tenth day pre lobotomy serves to demonstrate his low level of participation, his rejection of the projects offered by the therapist as contrasted with the favorable reactions of the other patients.

Using the sociogram as a study of the occupational therapist's response to patients and the technique used, it is seen that she spoke or responded to all patients in the room except Patient 1 who was attentive to the radio even within this short span of 15 minutes. Placing materials on the table, by itself, stimulated interest and curiosity without asking patients to do things. During this 15 minutes Patients 6 and 4 chose material and started work with no urging. The therapist conversed with seven patients, a total of 13 times during the 15 minutes, demonstrating her own willingness to socialize. Four of the conversations were initiated by the patients showing the extent to which she was responsive to them. However, she approached the more inactive patients, Patients 3 (K.M.) and 8 but did not press her suggestions. Her relationship with each patient could be separately evaluated in terms of their personalities and needs, giving a complete picture of a section of her functional ability.

3. Game Participation Chart.

An adaptation of the activity participation charts described in a previous article[1] is shown in Chart 3. It is specially useful in that more descriptive details may be included and by focusing on one activity at a time clearer information can be gained as to its effectiveness.

CHART 3 BINGO GAME



Bingo had been so well liked by the patients who could go to the occupational therapy department that the ward occupational therapist, Mrs. Anne C. Wood, O.T.R., considered introducing it to the acute wards, feeling that it might stimulate interest in patients otherwise inaccessible and uncooperative. This observation was made with the one purpose of determining whether bingo would be successful on the ward. The fact that bingo required additional money for prizes made it still more important that the therapist have definite data on its effectiveness.

By chance this observation included Patient K. M., now five days after his lobotomy operation. The observation is incomplete in that there was no record made of which patients won at bingo and how winning and losing affected their participation.

Ten patients participated in the bingo game, one of them becoming a leader, calling off numbers. Five of them participated spontaneously, as shown by the broken lines, 4 required leadership stimulation as shown by the unbroken lines and 1 showed withdrawal and was coaxed to continue. All patients in the room but one (Pt. 8) participated to some degree. Stimulation of interest in patients as sick and difficult to interest as these justified the inclusion of bingo as a ward occupational therapy project.

In this chart Patient K. M., No. 9, is seen

GAME PARTICIPATION SOCIOGRAM

INTRODUCTION OF BINGO TO ACUTE MALE WARD—March 31, 1948—3:00-4:00 p.m.

OBSERVER — Mrs. Anne C. Wood, O.T.R.

Diagnostic Description of Participants by Number

1. Dementia Praecox; expressed many mystical ideas and claimed clairevoyant powers, aged 33.
2. Manic Depressive Psychosis-Depressed Type; with wide mood swings from weeping self-mutilating depression to euphoria (5 days after lobotomy), aged 38.
3. Paranoid Condition; assaulted a political leader with an axe, aged 43.
4. Dementia Praecox-Catatonic Type; acute turmoil, much dissociation of thought, aged 27.
5. Dementia Praecox-Paranoid; preoccupied with sex and religion, wept and expressed guilt feelings, aged 19.
6. Without Psychosis-Psychopathic Personality with Pathological Sexuality, aged 59.
7. Dementia Praecox-Paranoid; with grandiose religious and political delusions (9 days after lobotomy), aged 60.
8. Without Psychosis-Psychopathic Personality with asocial and amoral trends, aged 28.
9. *Patient K. M.,* Dementia Praecox-Catatonic; confused, disturbed, resistive, seclusive (5 days after lobotomy), aged 24.
10. Without Psychosis-Psychopathic Personality with Pathological Emotionality also chronic alcoholism, aged 29.
11. Dementia Praecox-Catatonic; with great religious fervor and preoccupation with metaphysics and international affairs, aged 23.
12. Involutional Psychosis-Paranoid; irritable, depressed, deluded, aged 40.

St.—Students—Tufts College Sociology Field Work.

five days after his lobotomy operation, reading a magazine and watching the bingo game for a time, decidedly greater interest than was shown in Chart 2, 10 days before lobotomy, and consistent with the therapist's observation presented in Chart 1.

4. DESCRIPTION OBTAINED FROM FOCUSED SOCIOGRAM EIGHTEEN DAYS AFTER LOBOTOMY.

A similar observation to that in Chart 2 was made in the occupational therapy department except in this case it was focused on Patient K. M. It included all of his activities and interpersonal relations during one hour of observation. The verbal description of the first 15 minutes of the observation on April 13 is included here.

3:17 p.m. Patient working steadily on a leather pocket book. Watches an attendant who is talking loudly to some patients.
Watches two female patients who are talking and playing together.

3:20 p.m. Looks up from leather work when one of the female patients howls after being pinched by the other. He then continues to work steadily.

3:25 p.m. Watches two patients fix picture in vicinity. Looks up when vacuum cleaner is turned on.

3:30 p.m. A patient starts singing, Patient K.M. starts whistling. He glances at observer a couple of times.
People crowd room—he takes no notice. Patients take shellac from cupboard behind patient.
He notices them casually but keeps working on leather. Seems to have trouble with his leather work—shudders —looks at window then back at leather.

Here again the level of participation as recorded in Chart 1 by the occupational therapist was substantiated by an unbiased observer. The exact degree of the patient's interest was portrayed. The observation showed no interactions with the therapist and serves to show the extent to which the patient worked independently and was responsive to others.

The same patient, K. M., has been included here in a variety of observations, the first for Chart 1, made by the occupational therapist in the routine study of her work with lobotomy cases, the second and fourth made by other observers in a study of the changes in social behavior before and after lobotomy. The third chart was made by the therapist for a different reason, that of determining whether it would be feasible to introduce bingo games to the acute wards. The agreement of these varied

observations with their different goals demonstrates how these methods combine to give a well rounded picture.

DISCUSSION

An adequate occupational therapy program in any hospital requires a substantial investment of space, personnel and material, all of which may prove a burden to the hospital budget. It is, therefore, imperative that means be available to understand the effectiveness and the needs of an adequate occupational therapy program.

The methods outlined here seem particularly applicable to the therapist or hospital administrator who wishes to understand the areas of adequacy and inadequacy of a hospital occupational therapy program. These methods can be used in a primary survey of the occupational therapy department followed up by periodic surveys to determine what developments have taken place. The data are organized in such a way that they can be presented to the other individuals with whom the department's activities are integrated.

Every new project which is introduced into an occupational therapy program requires an expenditure of personnel, time, material, and often hospital space. Partly for this reason, and partly because no project should be undertaken the therapeutic effectiveness of which is not understood, it is important to study the value of the new project. Methods of determining patient participation and interest such as presented here are most useful.

Much of the work of an occupational therapy department is dependent upon a high degree of interdepartmental integration so it is necessary to understand just how and to what extent the different professional persons work together to bring about the best hospital experience for the patient. Without the assistance of others the therapist is able to carry on only a very small part of the activities which she could otherwise accomplish. There are usually proportionately large numbers of attendants, nurses, volunteers and student workers who are in close daily contact with patients. If the therapist can furnish these other workers with fundamental knowledge of occupational therapy techniques, such as can be demonstrated here in focused sociograms, then the other workers come to function as assistant therapists. A hospital which functions with, say, two professionally trained occupational therapists can be changed into one that functions with two occupational therapists assisted by sixty attendants and nurses. All the methods which are useful to the therapist in evaluating the effectiveness of the programs are useful in the teaching of other hospital personnel.

Another hospital department which should establish a close relation with occupational therapy is the psychology department. The educational background of the occupational therapist and the psychologist are quite complementary with the psychologist trained in research, experiment and controlled diagnostic studies, whereas the occupational therapist is trained in a therapeutic relationship involving the use of occupation and recreation. The psychologist can teach the occupational therapist the psychological implications of the patient's occupational therapy work and establish methods to record and interpret the patient's responses to the occupational therapy situations. In return the occupational therapist can show the patient's response to the course of treatment by practical tests involved in every occupational therapy activity they undertake, this information being particularly useful with the patient who is not cooperative in the more conventional testing procedures.

SUMMARY

Often the personnel of an occupational therapy department that is giving excellent service to a sizable group of patients fails to realize the total need of the hospital and calculate the extent to which it serves only a proportion of those patients who would benefit by occupational therapy, so the first step in evaluating the program was an attempt to calculate the proportion of patients served of all those in the hospital who needed it.

The quality of the program is more difficult to determine. First the program of Boston Psychopathic Hospital was described as to what activities were offered, the special activities available, the frequency of events, the proportion of patients receiving the most constructive activities. This was compared with an optimal program based on the estimate of the therapists of the hospital, and their knowledge of patient needs. Activity was available to somewhat less than two-thirds of the patients throughout the

day and evening. Marked deficiencies were pointed out particularly in the areas of (1) lack of sufficient variety of occupational therapy activities, (2) lack of activities which furnished good group socialization, (3) absence of choice of evening programs.

In this evaluation of the quality of the program it was evident that those activities which were most completely and effectively organized, patient government, pottery class, drama club, out-of-door activity, all came about through a high degree of cooperation with other departments of the hospital and the utilization of volunteer leaders and assistants from many sources.

The quality of the program was further considered from the point of view of its special attention to the important periods in the patient's hospital life. Here again it was evident that close interdepartmental relations were necessary to give adequate occupational therapy to the newly arrived patient, the patient who was acutely ill, the patient when he leaves and after he leaves the hospital.

Determining the patient's subjective attitude toward the program as an important method of discovering the weaknesses and strengths of the program was presented as a useful method which could be conducted with the assistance of psychiatric nurse, psychiatric case worker or clinical psychologist. While this paper was in progress another source of evaluation was discovered. The patients' government of the convalescent wards spontaneously undertook a survey of patient hobby and occupational interests and how the hospital program could be improved by the patients' government to satisfy these interests.

A time study of each regular worker in the occupational therapy department gave a useful index of the effectiveness of their use of time. It showed a large proportion used in teaching others (students, volunteers, personnel or other departments and patient leaders) to work with patients. It showed insufficient occupational coverage for adequate research and occupational therapy for out patients.

The extent to which a program is dependent upon the assistance of persons outside the department was demonstrated. The necessity of the occupational therapist gaining the assistance of the many other persons in the hospital and of volunteers and students from the outside was shown by tabulating the average number of workers assisting in each phase of the program.

Sociometric methods were presented for studying the therapist's response to patients, her methods, the patients' response to therapist and each other, the effectiveness of the activities used. These together with the conventional methods of case presentation furnish methods whereby the therapist can make further studies of her effectiveness and present her findings to others.

This outline of evaluation of an occupational therapy program is of introductory nature. Every area of evaluation presented here requires intensive study and research. Some such beginning as this is essential, and will, we hope, with further systematic evaluation here and elsewhere, lead to a real understanding of what occupational therapy has to offer, what it accomplishes and the methods necessary for bringing about the accomplishment.

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A Technique for Investigating Interpersonal Relationships in a Mental Hospital

(The following excerpts are reprinted by permission from "A Technique for Investigating Interpersonal Relationships in a Mental Hospital" by ROBERT W. HYDE *and* RICHARD H. YORK, *Boston Psychopathic Hospital, appearing in the July, 1948 issue of* THE JOURNAL OF ABNORMAL AND SOCIAL PSYCHOLOGY.)

The need for understanding the interpersonal relations of patients within the mental hospital is intensely felt at this time when there is an increasing emphasis placed upon all forms of group work and group therapy. Patients come to mental hospitals primarily because of their inability to get along with people in the community and at work. Whatever the basic personality or thought disturbance, it is usually the social manifestations which cause admission to the mental hospital. Although social recovery is one of the prime goals of treatment, techniques for evaluating social progress and recovery are extremely crude at this time.

METHOD

The following procedure was followed:

The observer enters the room, sits in an inconspicuous place, and keeps his own activity to a minimum. The first five minutes is a preparatory period during which whatever initial disturbance he may have created usually subsides. He utilizes this period recording the primary situation, names or descriptive identification of each person present, and their approximate location with respect to each other.

At the end of the preliminary five-minute period the observation starts. The observer records in sequence the spontaneous activity taking place for fifteen minutes. He diagrams this activity with auxiliary written description, in time sequence, observing who originates activity, of what type, and the response of the others in the room to that activity.

Four main categories of action-interaction have been designated: verbal, which includes talking, laughing, and reacting to autistic thinking; attention, which consists of looking in the direction of a specific, identifiable stimulus; action or movement which so far has been restricted to gross movement in and out of the room and significant gestures between patients; none, which is important for recording the absence of a person's response to a stimulus. This study so far is not sufficiently conclusive to enable us to define precisely the units of action as to type, duration, and intensity. This method, however, should be useful in further studies to isolate meaningful aspects of spontaneous interaction.

Each individual is represented by a diamond, each side of which indicates one of the four factors above. The upper right side of the diamond is the "attention" factor, the lower right "verbal," the lower left "action," and the upper left "none." When patient 1 speaks to patient 2, who in turn responds, a line representing interaction is drawn from the verbal side (lower right) of diamond 1 and terminates at the lower right (verbal) side of diamond 2. If 2 had not responded verbally but merely by motion or attention or not at all, the line from 1 would have terminated on the appropriate side of his diamond. Thus the place of termination of the line illustrates the character of the response. The direction of the activity is shown by an arrow on the line pointing from the person who originated it to the recipient. Movement is shown by a dotted line arising from the action (lower left) face of the diamond, and the arrow on the line indicates the social direction of the movement. Double-sided diamonds are for people other than patients. Colored or dotted-sided diamonds may be used for changing position.

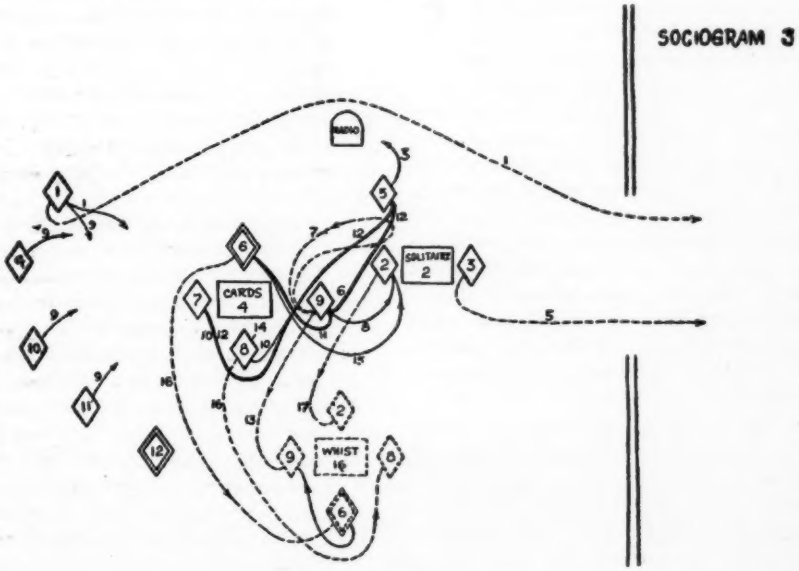
Each interaction is numbered to record the time sequence, and the content of verbalization or characterization of the activity is recorded.

SOCIOGRAM 3

Ward 2, Smoking Room — Feb. 20, 1947, 3:05-3:20 P.M.

Diagnostic Description of Participants by Number

1. Psychosis with general paresis—suspicious and deluded—age 56
2. Dementia praecox—paranoid—with impulsiveness and seclusiveness—age 22
3. Psychosis with general paresis—quiet and confused—age 53
4. Undiagnosed psychosis—with delusions, depression, withdrawal—age 22
5. Without psychosis—seclusive, tense and depressed—age 20
6. Student occupational therapist
7. Without psychosis—congenital syphillis and psychopathic traits—age 25
8. Manic depressive—manic—with delusions and hallucinations—age 24
9. Psychopathic personality—emotional instability, suicidal—age 30
10. Senile psychosis—with retardation, confusion, and paranoid ideas—age 50
11. Manic depressive—depressed—with delusions, apathy, alcoholism—age 51



Description of Activity in Sequence

1. Patient 1 does a jig out of the room, saying, "Going to bed now," in a jovial manner to everyone.
2. Patients 2 and 3 alternate at solitaire.
3. Patient 5 listening to the radio.
4. O.T. 6 and patients 7 and 8 playing cards.
5. Patient 3 left the room.
6. Patients 9 and 5 hold low conversation.
7. Patient 9 walked over to look at 2 playing solitaire and sat back down.
8. Patients 9 and 2 talk about the game.
9. Patients 4, 10, and 11 pay attention to game and activity.
10. Card game (activity 4) broken up; 6, 7, and 8 discuss game and 5 joins in.
11. Patient 9 asks 6 what they are playing and walks over to table where they are.
12. O.T. 6 and patients 5, 7, and 9 discuss games and general topics.
13. Patient 9 sits on bench away from game.
14. Patient 8 reads magazine.
15. O.T. 6 asked patient 2, "Want to play whist?" Response, "Rather play solitaire."
16. Patients 8 and 9 joined 6 for whist, 9 responding to 6.
17. Patient 2 then joins them at the game.

Sociogram 3 — February 20, 1947

The predominant activity recorded in this observation was that of games introduced by the occupational therapy student present. The socializing effect of this activity upon the group is objectively portrayed and the degrees of participation of the people present recorded.

In recording the observation the detailed interactions of each game group were necessarily disregarded. The observer was able to concentrate on any interruptions in the game activity and on the response of the other patients in the room to this central stimulus.

The following patients entered into the game activity, responding to others and at times originating verbal remarks: Patient 7, aged 25, diagnosis without psychosis, described clinically as "unstable, lewd" and in progress notes as "cooperative, mixes well"; patient 8, aged 24, manic depressivemanic (patient 4 in Sociogram 1), described now as "overactive, bizarre ideas, helpful, mixes well"; patient 9, aged 30, psychopathic personality with emotional instability, described as "helpful, sociable"; patient 2, aged 22, dementia praecox-paranoid, clinical description "impulsive, unstable," nurses' notes "cooperative, seclusive"; patient 3, aged 53, general paresis, described as "quiet, cooperative, mixes well."

Here four of the five patients who participated in games were described clinically as mixing well or helpful. Only patient 2 was described as seclusive. It will be noticed on the sociogram that patient 2 was first alternating at solitaire with patient 3 and continued playing when patient 3 left the room, that he talked with 9 about the game. When asked by occupational therapist, "Want to play whist?" he responded, "Rather play solitaire," but joined the whist group after it was started by the other patients. Here is an objectified picture of the level of socialization of patient 2 not furnished by the clinical description.

Patient 1 left the room during the first minute of observation with a friendly good night remark to everyone; patient 5, without psychosis, but clinically described as "seclusive, tense, depressed" and in nursing notes as "mixes well, cooperative," paid attention to the game activity and at end of first game approached the same group and discussed the game.

Three patients who did not speak during the observation period and participated only by paying intermittent attention to the central game activity were: patient 4, aged 22, undiagnosed psychosis, "unstable, withdrawn, deluded, depressed" and in nursing notes for the day as "cooperative, seclusive, confused"; patient 10, aged 50, senile psychosis, "retarded, confused, paranoid ideas" and in nursing notes as "dejected, uninterested in environment, seemingly does not comprehend what is said to him"; patient 11, aged 51, manic depressive-depressed, "delusions, depressed, apathetic" and in nursing notes for the day as "very seclusive."

The three patients whose clinical description suggested the greatest distortion of thinking and mood were those who participated only at the level of giving intermittent attention to the stimulus of the central game activity, whereas four of the five patients who engaged in game activity were described as "mixing well, cooperative."

As in Sociogram 2, the interactions between personnel and patients were very important. Here, however, rather than personnel only initiating single contacts with patients, the occupational therapist was able to bring about a favorable degree of group socialization. Even when her first group broke up she took an important part in a conversational group on games and was successful in instigating a new game.

Her interaction with patient 2 was interesting. Here she simply proposed to the patient, "Want to play whist?" When he responded, "Rather play solitaire," she did not press the point. Patient 2 spontaneously entered the game after the other two patients had joined her for this activity. Here is an objective picture of technique of interpersonal relations between personnel and patient, an area about which we should know more.

The importance of the skillful introduction of games to ward socialization is shown in this sociogram, suggesting that the technique would find special application in developing more objective criteria of the indications, technique, and measurement of effectiveness of various recreations.

The use of test games as test situations from which to judge the level of responsiveness of patients is also suggested here and studies are being made.

FEATURED O. T. DEPARTMENTS

Georgia Warm Springs Foundation

CHARLOTTE E. STEITZ, O.T.R., *Chief Occupational Therapist*

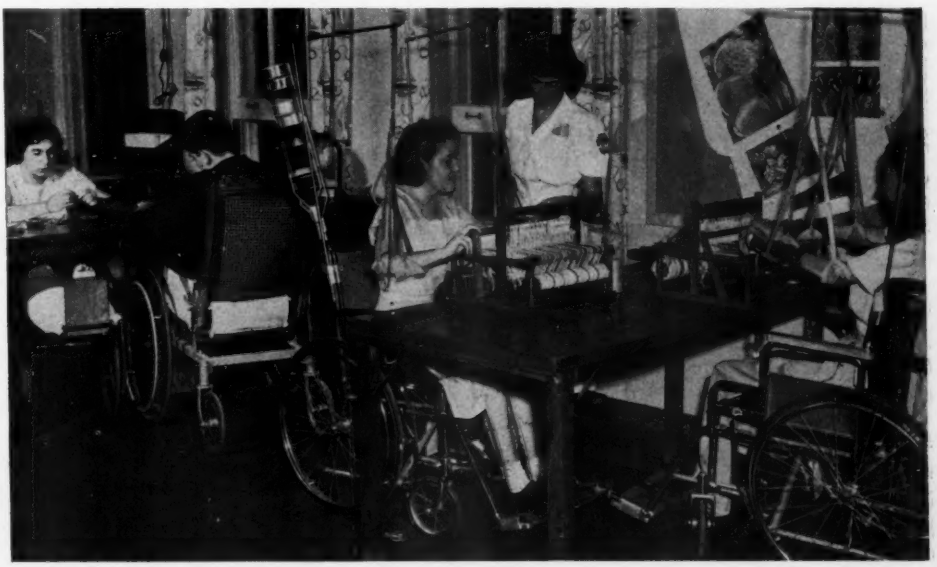
The year 1947 marked the twentieth anniversary of the founding of the Georgia Warm Springs Foundation, the first and largest hospital devoted exclusively to the treatment of the after-effects of poliomyelitis. It was to this place, then a small summer resort known for its natural warm springs, that Franklin D. Roosevelt came in 1924 . . . and it was here, twenty-one years later, that he died.

Convinced by his own progress and that of the other "guest-patients" and encouraged by outstanding physicians and friends, Mr. Roosevelt with four other interested men formed the Georgia Warm Springs Foundation. The Foundation was created in 1927 as a non-profit institution having two objectives:

1. To use the natural facilities of Warm Springs and the skill of an able, carefully selected professional staff for the direct aid of patients.
2. To pass on the the medical profession and to hospitals throughout the land any useful observations or special methods of proved merit resulting from this specialized work which might be applied elsewhere.

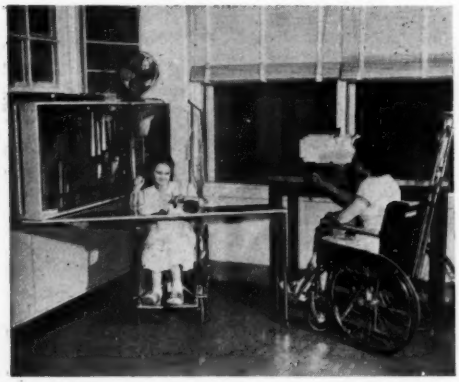
A tremendous change has taken place since 1927. From a center having an inn, several guest cottages, a resort pool, 71 patients, and 110 staff members, it has grown into a complete community. This institution gave treatment to 799 patients in 1947, representing 43 states, District of Columbia, Puerto Rico, and fourteen foreign countries. It now possesses within its approximately 300 acres a modern medical building, dormitories, administration building, new patients' pool, chapel, fire department, heating plant, staff cottages, golf course, playhouse (where free movies, lectures, and patient-directed musicals are held), etc. Although a hospital of world reputation, there is at Warm Springs more of the atmosphere of a college campus than a hospital.

In 1939, the school house building was do-



nated, incorporating a library, individual class rooms and a spacious craft shop (the beginning of occupational therapy here). Since this date, the Foundation school system has expanded to a department of eight teachers offering both bedside and classroom study.

The average stay of a patient is about three months, although many have stayed for a year or more. The majority of the patients receive some financial assistance, generally through their local chapters of the National Foundation for Infantile Paralysis supported by the March of Dimes. No distinction, however, is ever made between pay and aid patients in either care or housing.



The Georgia Warm Springs Foundation is a world recognized training center for professional workers in the treatment of the after-effects of poliomyelitis.

There are resident doctors training in both orthopedic surgery and physical medicine. There is a physical therapy post-graduate school offering training in muscle testing, muscle re-education, hydrotherapy, walking re-education, body mechanics, remedial activities, and the use of assistive and supportive apparatus. Each student therapist receives a scholarship (a small stipend and room and board) through a grant from the National Foundation for Infantile Paralysis. The Warm Springs Brace Shop—large, modern, and fully equipped—offers training to bracemakers under the GI Plan. Under an extension of the grant for post-graduate training of physical therapists at Warm Springs, qualified occupational therapists may now apply for admission to the post-graduate three to six months course along with the physical therapists.

A grant of $11,260.00 was set up in 1947 by the National Foundation for Infantile Paralysis for the express purpose of conducting a year's research into the field of functional occupational therapy and its role in the treatment of the after-effects of poliomyelitis. Many developments resulted from the year's research, such as the formulation of a functional evaluation test, carefully graded to determine each patient's functional capacity; functional occupational therapy studies; establishment of a permanent occupational therapy department; and the creation of a remedial activities department. This later department is staffed by both physical therapists and occupational therapists and incorporates a patient training program in self-care and personal independence activities, resistive exercises and gymnasium program, occupational therapy, craft activities, and recreation.

The occupational therapy department, consisting of one director and three staff members, is still carrying on an extensive research program. The physical set-up of the department has grown to include two large, specially designed occupational therapy divisions located in different sections of the Foundation to accommodate both the severely handicapped and the more able-bodied patients. The functional occupational therapy program includes activities for muscle strengthening and re-education, joint motion, functional training, and training in the

use of assistive and supportive apparatus. Although the majority of the patient load in the shops and on the wards is functional, the department carries on a general diversional program as well as a weekly recreation hour for the youngest children.

Few people realize that poliomyelitis strikes the older age group as well as the young. Of the 799 patients registered at Warm Springs in 1947, 525 were over fifteen years old and 102 of these were over 30 years of age. Therefore, much of the occupational therapy work, particularly with the more severely involved, is of necessity, prevocational in nature. Warm Springs is an official United States Navy Center for the treatment of the after-effects of poliomyelitis; and both the state and Veterans Bureau send rehabilitation and vocational agents at frequent intervals to interview and guide patients.

As poliomyelitis never affects two people in exactly the same fashion, each patient presents a very strong and individual challenge to the therapist. Work in this field incorporates many of the principles of orthopedics, psychology, social work, job analysis, job placement, functional training and education. There is a definite place for the alert occupational therapist vitally interested in research and team work in the treatment of the after-effects of poliomyelitis.

N. Y. State Rehabilitation Hospital

West Haverstraw, New York

VIOLA W. SVENSSON, O.T.R., *Acting Director*

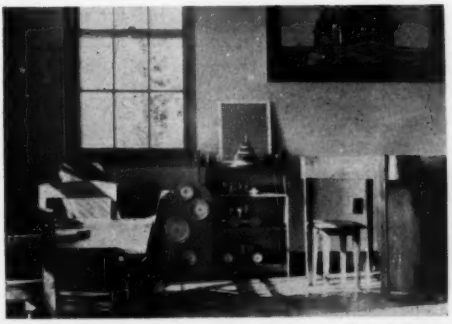
OCCUPATIONAL THERAPY ON AN ORTHOPEDIC-MEDICAL BASIS

Just Plans

The New York State Rehabilitation Hospital, primarily a polio center with a great variety of orthopedic cases and some cerebral palsy, is fast becoming a center for the orthopedically exceptional to learn new ways and means to meet daily activities and living demands through the extensive facilities now available. Occupational Therapy inaugurated its program over three years ago, directing its services toward the orthopedic field. Having justified support for this field, a budget request for equipment, supplies and staff was submitted to the Department of Health in Albany. The requests were approved and a new department came into being.

The Second Stage

As equipment and materials were received, the program became a reality. Within a year, the staff consisted of three registered therapists. One large room contained the main activities and later a power woodwork shop was added. With more intensive organization, a student program began with Columbia University. We were contributing and progressing!



Cerebral Palsy Area in the General Activity Shop

Functional Woodworking Shop

Layout Expansion

By the three-month requisition system, the Occupational Therapy budget was spread out to set up the orthopedic department. While this process continued, the patients were formed into constructive recreational groups and council activities were carried out. Rooms were cleaned and prepared for Occupational Therapy occupancy. Nearly two years elapsed while Occupational Therapy spread its wings into other shops. Moving to advantageous rooms gave the program an impetus needed to justify the long-range plans made.

Today the department has seven shops named for their basic equipment and to facilitate their location by the patients.

General Activities Shop

1. THE GENERAL ACTIVITIES ROOM on the first floor is large and it has an adjoining supply room. The name well implies its contents . . . everything! This room accommodates short-time scheduled patients, difficult transportation problems, some recreational patients and a concentrated Cerebral Palsy treatment in a curtained-off area.

2. A POWER WOODWORKING SHOP has most of the fundamental power tools to provide an excellent training program of prevocational evaluation, and introduction of power work. Sanders, drill presses, jig saws, lathes, saws, and other tools are available with plans for increasing such equipment within our scope. All patients attend under strict supervision.

3. A METAL AND PLASTIC SHOP contains our varied supply of such materials. Plans for further augmenting the equipment and scope of work are being carried out.

4. THE FUNCTIONAL WOODWORKING SHOP admits a general set-up and allows us to concentrate on upper and lower extremity treatment with the use of the jig saws and treadle saw in particular. Where wheel chairs are predominant, we find adjustments must be made in setting up shop facilities and placing equipment to allow movement up to and around these pieces. Consequently, exceedingly more space than usual is required to house useful occupational therapy facilities in a rehabilitation program.

5. THE CERAMIC SHOP is a proud unit of ours! It is complete for basic needs and is set up to accommodate an enlarging scope of work. A floor kiln, all types of glazes and necessary hand tools help toward producing an efficient program. This unit is extremely satisfactory to all since it allows the patients to follow through the whole process from the raw clay to the glazed piece. It is used for exercise of the muscles of the upper extremity, and particularly for pre-operative and post-operative opponens pollicis. Our kick wheel, with a therapist assisting, allows patients to gain tolerance for standing and balance in long leg braces.

6. THE PRINT SHOP is next and is well equipped with two stirrup presses and other necessary equipment with many styles of type. The future possibilities of printing increase as more definite thoughts turn to prevocational emphasis together with orthopedic applications. In this shop we have other crafts pertaining to printing — stenciling, block printing, silk screen and etching.

7. THE PHOTOGRAPHY ROOM is used by patients during the day and early evening, whenever it is free of treatments for an hour or more. Facilities available allow initiative in learning developing, printing and enlarging. This unit has proved most successful for a number of wheel chair patients. Learning to accommodate to such activities from a chair, plus increasing possible interest in hobbies, has more than justified its organization.

And there we have, more or less, the department's physical plant. The staff, of course, had to be augumented in ratio to the increasing importance of orthopedic treatments and prevocational training. As we improved in phys-

ical set-up, our scopes expanded—all toward building an up-to-date and inclusive program of rehabilitation.

The Third Stage—Eight Times As Effective

Having started with one therapist, we now have eight who are assisted by a secretary, two occupational therapy aides and two hospital attendants. Can there be more improvement and expansion? Yes, indeed. We have graduated from the first rung of the ladder, that is all. Possibilities of a Cerebral Palsy Unit and an increased population of polio patients call for additional application of rehabilitation techniques to complete a worthwhile unit.

In April, 1947, when there was a staff of three, the department (still in the elementary organizational phase as to location, equipment and supplies) treated orthopedically and recreationally about 95 patients with a resulting number of treatments (based on attendance a day) of 509 per month. In September, 1948, with increased staff and settled quarters, attendance grew to 139 patients and treatments ranged up to 1572. Each therapist carried between 19 and 22 patients. Cerebral Palsied accounted for 28-30 patients in daily half-hour individual treatments. As rehabilitation demands become more inclusive and as the hospital expands its facilities staffs must increase in number, scope, and adaptability of knowledge. A complete service of aiding and teaching the physically disabled to become as independent as possible in all spheres is the goal—and Occupational Therapy must give effectively to this total picture.

What of Physical Medicine?

We have it, and it is working out well, progressing as we grow older and wiser. The nucleus is composed of Physical Therapy, Physical Rehabilitation Section, and Occupational Therapy. Into this group come the other departments such as Psychology, Nursing, Social Service, and School. All sorts of concentrated meetings are held such as physical medicine rounds on the wards with all ward surgeons to discuss specifically the patient's total program of rehabilitation.

Complete staffs of each three sections of Physical Medicine gather twice a month to discuss jointly new ideas and treatment programs for staff education and increased understanding among all departments, thus developing the most realistic rehabilitation possible.

Power Woodworking Shop

Occupational Therapy joins with Physical Therapy, Rehabilitation Section and School in proportioning the patients' daily treatment schedules. Who gets the head, arms, or legs is decided—all to the patient's benefit, of course. Here again Occupational Therapy has an opportunity to participate as one of the major factors in determining where the patient can best be benefited in a concentrated treatment area.

All patients attending Occupational Therapy in any capacity have their treatments scheduled and prescribed by the ward surgeon. Progress notes are made at certain intervals, and patients discharge notes and recommendations are made to the District State Health Offices at the termination of treatment.

Prevocational Testing and Evaluation

Here, we are starting out new—experimenting, discarding, improving, and adding ideas—to produce some day soon a basic test for the majority of physical disabilities in respect to manual dexterity and shop instruction. This

Ceramic Shop

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program is carried on as an aid to the State Division of Vocational Rehabilitation. Upon recommendations by the counselor, patients are tested to determine work habits and abilities for future schooling, jobs, or homebound possibilities. *At no time do we teach a trade!* The Rehabilitation Section enters the picture at this point since it is concerned with the practical aspects of correlating locomotion with ability, interest and training. No department here can exist or do a complete job without all others contributing and dovetailing their technical knowledge and work programs.

What Does the Future Hold?

We don't know. Every day shows progress. Daily, ideas are discussed, programs evaluated and then incorporated as they prove useful. If systems become cumbersome, we discard them, in Physical Medicine group meetings, for a better method. It is fun, exciting, and well-worth the work required to put into actuality such a proposed rehabilitation program as is being established here. Occupational Therapy is, indeed, fortunate to have been on the ground floor of such development. The total program, as a cooperating unit, is less than three years old, yet the results are tremendously encouraging. Our chief aspiration is to have the patient work as hard as others have worked to create a successful program which will benefit him personally. Although the program is by no means accomplished, it is generally felt that the New York State Rehabilitation Hospital can be proud of the progress which has been made so far by its team for rehabilitating the orthopedically exceptional.

Photographs taken, developed, and enlarged by a patient in the Occupational Therapy photography room.

O.T. ITEMS

Worry is like a rocking chair—it will give you something to do but it won't get you anywhere.

To make an old garden hose last one year longer, try giving it a coat of pliable roofing paint.

Remember that vaseline, smeared around the tops of shellac, glue, and tempera jars, will make the covers easier to remove.

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Marguerite Abbott, O.T.R., Chairman
Assoc. Dir., O.T. Training Courses
College of Physicians and Surgeons
Columbia University, New York, N. Y.

RESEARCH COMMITTEE ON POLIOMYELITIS
Sue P. Hurt, O.T.R., Chairman
Dir. O.T., Washington University School of
Medicine, St. Louis 10, Missouri

RULES AND PROCEDURES COMMITTEE
Sister Jeanne Marie, O.T.R., Chairman
Dir. O.T., College of St. Catherine
St. Paul 1, Minnesota

VOLUNTEER ASSISTANTS' TRAINING COURSE
Carolyn Weil Oppenheimer, O.T.R., Chairman
1148 Fifth Avenue, New York, New York

DELEGATES DIVISION

Dorothy L. Flint, O.T.R., Editor

HOUSE OF DELEGATES

Speaker of the House	Edna Faeser, O.T.R.
Vice Speaker	Josephine Davis, O.T.R.
Secretary	Elizabeth Collins, O.T.R.
California, Northern	Meryl Van Vlack, O.T.R.
California, Southern	Carlotta Welles, O.T.R.
Colorado	Josephine Davis, O.T.R.
Connecticut	Bertha J. Piper, O.T.R.
District of Columbia	Violet H. Corliss, O.T.R.
Hawaii	Esther Pyun, O.T.R.
Illinois	Angelina Howard, O.T.R.
Indiana	Edna Faeser, O.T.R.
Iowa	Maxine Farrell, O.T.R.
Kansas	Nancy Greenman, O.T.R.
Kentucky	Nell McCulloch, O.T.R.
Maryland	Eleanor Owen, O.T.R.
Massachusetts	Elizabeth Collins, O.T.R.
Michigan	Marion R. Spear, O.T.R.
Minnesota	Borghild Hansen, O.T.R.
Missouri	Dorothy Flint, O.T.R.
New England, Northern	Doris Wilkins, O.T.R.
New Jersey	Naida Ackley, O.T.R.
New York	Harriet J. Tiebel, O.T.R.
New York, Western	Cornelia Smith, O.T.R.
Ohio	Minnie Fevold, O.T.R.
Oregon	Caroline Haskins, O.T.R.
Pennsylvania	Eleanor Randall, O.T.R.
Pennsylvania, Western	Bessie Clark, O.T.R.
Texas	Lenore Brannon, O.T.R.
Virginia	Mary Junkin, O.T.R.
Washington	Edna-Ellen Bell, O.T.R.
Wisconsin	Janice Olson, O.T.R.

MASSACHUSETTS

Delegate-Reporter, Elizabeth Collins, O.T.R.

MEETINGS: Prior to the 1947 A.O.T.A. Convention in California the Massachusetts Association for Occupational Therapy held a short general membership business meeting in order to instruct the delegate.

Following the delegate's return from the convention a joint business and educational membership meeting was held. At that time the delegate reported on Convention business and highlights. The guest speaker of the day was Dr. Robert Arnot of the Boston Psychopathic Hospital who spoke on Lobotomies, their purpose and the role which occupational therapists play in the treatment of post lobotomy patients. With lobotomies becoming more prevalent and therefore more numerous in occupational therapy case loads the therapists of the M.A.O.T. were grateful for the opportunity to gain more knowledge of the comparatively new therapy.

The third membership meeting was held in conjunction with the Massachusetts Physical Therapy Association at the Massachusetts General Hospital. Following dinner, Dr. Marion Ropes of The Massachusetts General Hospital Staff spoke to the approximately two hundred therapists present about arthritis, with special emphasis upon rheumatoid arthritis and the role which occupational and physical therapy play in the treatment of these patients. There was an excellent discussion following Dr. Rope's lecture which gave those present an opportunity to ask many questions concerning this disease. It is hoped that a joint physical therapy and occupational therapy meeting may become an annual affair.

At the Annual Meeting on May 14 at the Hotel Sheraton in Boston a business meeting was held in the morning at which time new officers and committee chairmen were elected. After a delicious luncheon Dr. Harold Storms, Director of Physical Medicine, Convalescent Center, Malton, Ontario, presented an extremely stimulating lecture, illustrated by colored slides on the "Correlation of P.T. and O.T. in the Rehabilitation Program." This was followed by an interesting question period at which time Dr. Storms went into further detail about an occupational therapy course which he would like to see developed.

Since the annual election of officers Miss Nancy Martin, O.T.R., who was Alternate Delegate designed and Miss Elizabeth Collins, O.T.R., was appointed to fill the unexpired term. In July Miss Jane Merrill, O.T.R., submitted her resignation as Delegate. This was accepted with regret. Miss Collins was then appointed to fill the delegate's unexpired term and as yet a new alternate has not been appointed.

PROJECTS: During Miss Barbara Stow's visit from England she spoke of the great shortage of occupational therapy equipment in her country. At that time the M.A.O.T. asked if she would submit a list of items she would like for her department and if they were available our association would consider it a privilege to send as many things as possible. The first bundle has been sent and received in England and a second package is being prepared for shipment.

REHABILITATION: With an increasing interest in rehabilitation the M.A.O.T. has appointed a special committee to attend rehabilitation meetings which are held in this area, to correlate material and present this information to the general membership. This committee has become increasingly aware of the lack of understanding of occupational therapy and of its place in the field of rehabilitation. It is hoped that by attending and participating in as many rehabilitation meetings and discussion as possible that occupational therapy will gain its rightful position in the rehabilitation activities.

CIVIL SERVICE: The therapists employed in Massachusetts state institutions have received a twenty per cent increase in salaries under Massachusetts House Bill No. 268. Through the capable work of Mrs. Ione Johnson, O.T.R., Chairman of the Civil Service Committee of M.A.O.T., occupational therapy has been brought to the attention of many of the State legislators.

PUBLIC RELATIONS COMMITTEE: This past year a committee was established which was to be known as the Public Relations Committee. This would include the previously existing separate committees of Exhibit, Program, and Publicity. It was hoped that through a coordinator these groups, each still headed by a chairman, that a stronger educational program could be carried out. To date this plan has been very successful. We have been fortunate in being able to have newspaper space for coverage and pictures of meetings and items of importance. Our association has presented several exhibitions at large medical and hospital meetings as well as at smaller gatherings.

OFFICERS

President: Olive Campbell, O.T.R., Danvers State Hospital, Hathorne.

Vice President: Ione Johnson, O.T.R., Gardner State Hospital, East Gardner.

Secretary: Mehitabel Millar, O.T.R., Community Workshops, Boston.

Treasurer: Joan Gauchat, O.T.R., U. S. Marine Hospital, Brighton.

Delegate: Elizabeth Collins, O.T.R., Robert Breck Brigham Hospital, Boston.

NEW YORK

Delegate-Reporter, Harriet J. Tiebel

The New York State Association of Occupational Therapists has a membership of 155 active members, 15 associate members, and 9 student members. Due to the active work of the Membership Committee, led by Frances Howard O'Brien, 20 new members joined the Association during the past year.

Four program meetings were held during the year. The first was the Fall Dinner Meeting at Bard Hall, Columbia-Presbyterian Medical Center on October 29. Miss Irene Hilton, a member of the English Association and a Board member of Dorset House, gave an interesting address on postwar Occupational Therapy in England. Gifts were presented for members of the AOTA to Mrs. Meta Cobb and Mr. Holland Hudson in appreciation of their splendid services to the American Occupational Therapy Association.

On January 22 a Round Table Discussion Meeting was held in the Occupational Therapy Department of the Payne Whitney Clinic. The four discussion groups were: (1) Occupational Therapy with Vocational Potentialities in T B, led by Julia Olivo, (2) Cerebral Palsy, led by Stella Miner, (3) Diversional Therapy, led by Ruth Bradshaw, and (4) Coordination of Occupational Therapy and Physical Therapy, led by Marguerite Abbott. Following the discussions, summaries were given by the secretary of each group. A social hour followed and refreshments served.

The Fifth Annual Joint Meeting with the New York Chapter of the American Physical Therapy Association was held on March 17 in the Einhorn Auditorium of the Lenox Hill Hospital. Dr. Hans Kraus, Chief of Clinics, Vanderbilt Clinic, Columbia-Presbyterian Medical Center, gave a talk and demonstration of "Exercises for Low-Back Conditions." Dr. Mary J. Sherfey, Research Psychiatrist of the Payne Whitney Clinic, Cornell Medical Center, addressed the associations on "Present Day Treatment in Alcoholism." The meeting was well attended by both associations.

The final meeting of the year, the Annual Conference, was held on May 14 at the Hotel Pennsylvania. The morning session was confined to a business meeting, followed by luncheon, during which Miss Wilma West and Miss Virginia Scullin spoke. During the afternoon session the speakers were Dr. Justin Greene, of the Neurological Institute, who spoke on "Some Factors in the Habilitation of Children with Congenital Athetosis," Dr. A. N. Aitkin, Medical Director of Niagara Sanatorium, who spoke on "Values of Occupational Therapy in the Rehabilitation of the Tuberculosis Patient," and Mr. John R. Saunders, Associate Curator of Education at the American Museum of Natural History, who spoke on "Museum Services and Untapped Resources" with illustrations of museum functions. On Saturday, May 15, field trips were arranged to Triborough Hospital and to the Institute of Rehabilitation and Physical Medicine, a unit of the New York University-Bellevue Medical Center. These programs were planned under the direction of Miss Mildred Spargo.

The Bulletin Committee, under Julia Olivo and assisted by Patricia Laurencelle, produced four issues of the Bulletin during the year. The Institute Committee, headed by Marguerite Abbott, planned the Joint Physical and Occupational Therapy Institute held at the Nurses' Home of New York Hospital. Ten lectures were presented one evening a week, beginning February 5. The physical therapists presented the first five lectures and the occupational therapists the last five. The subjects were diagnoses pertinent to both physical and occupational therapy. The fee charged for the course was ten dollars. Twenty-three occupational therapists and fifty or more physical therapists registered.

The Volunteer Committee, functioning actively under the leadership of Mrs. Edgar Oppenheimer, has a new office for headquarters for their Volunteer Course in the International Business Machines Building in New York City. A new volunteer course is to begin in October

of this year.

The Legislation Committee, with Mrs. Blanche Ringel as chairman, has been studying federal, city and state civil service and has been inquiring into legislation in other localities.

The New York State Association has been represented on the recently formed Health Organizations Committee of the Women's National Institute in New York City. The chief work of this committee has been to find ways of bringing before the general public opportunities for young women in the professions allied to medicine and health. A survey of each profession is to be made, and the results combined in a pamphlet for distribution in the high schools of New York City and at the Women's International Institute to be held in New York in November.

OFFICERS

President; Miss Susan Colston Wilson, O.T.R., Chief Occupational Therapist, Brooklyn State Hospital, Brooklyn, N. Y.

1st Vice President and Delegate: Mrs. Harriet J. Tiebel, O.T.R., 10 Ward St., Floral Park, N. Y.

2nd Vice President: Mrs. Elizabeth L. Jameson, O.T.R., Veterans' Administration Hospital, 130 Kingsbridge Road, New York City.

Secretary: Orvilla D. Yost, O.T.R., Halloran Veterans' Hospital, Staten Island, N. Y.

Ass't Secretary: Norma Allessandrini, O.T.R., Children's Recreation Unit, Bellevue Hospital, New York City.

Treasurer: Mrs. Frances Howard O'Brien, O.T.R., City Hospital, Welfare Island, New York City.

Ass't Treasurer: Anna Slavin, O.T.R., New York State Rehabilitation Division, New York City.

Alternate: Mrs. Blanche Ringel, O.T.R., Hospital for Joint Diseases, New York City.

IOWA

Delegate-Reporter, Maxine Ferrell, O.T.R.

The IOTA has held two meetings since last reporting in the October 1947 issue of AJOT. A group of us also participated in the Minnesota State Association meeting which was held in conjunction with the Upper Mid-West Hospital Conference in Minneapolis June 3-6th. Seven of our members were able to make the trip and we had a most enjoyable time touring the various O.T. departments in that city. We hope to have many more inter-group meetings between our two associations.

Meetings: The fall 1947 meeting was a two day affair held in Iowa City, on the 17th and 18th of October. We were pleased to have four members from the Minnesota Association with us at this time. An excellent program was planned for us by Miss Jean Lovett. First day activities included: "P.T. Demonstration" by Mrs. Olive Garr, Instructor of P.T., State University of Iowa; "Medical Aspects of Poliomyelitis," Orrie A. Couch, M.D., State University of Iowa; "Medical Aspects of Cerebral Palsy," Arthur Steindler, M.D., head of Orthopedic Department, State University of Iowa; "Speechwork in Cerebral Palsy," Spencer F. Brown, Ph.D., Associate Professor of Psychology and Speech Clinic, State University of Iowa. A luncheon at the Hotel Jefferson was held after these lectures. An auction of craft articles by O.T.'s highlighted the afternoon events, and brought a total of $48.35 to our treasury. Open House to the various O.T. units on the State University of Iowa campus and movies completed the day's program. The second day program was a business meeting concerned with instruction to our delegates to the 1947 November convention in California. Two lectures were also given: "Rehabilitation Program at the State Sanatorium," Nell Norey, Director Vocational Rehabilitations, Oakdale, Iowa; "Rehabilitation," Clayton Gerken, Technical Director of Veterans Administration Guidance Center, State University of Iowa.

The annual Spring Meeting was held rather late due to the desire of the members to attend the Mid-West Hospital Conference in Minneapolis. We finally arranged a one day meeting for July 10th in Des Moines, Iowa. In spite of this meeting being primarily planned for business, we had a record turn-out of 15 active members as well as a large group of guests and interested associate members. Five new registered O.T.'s were added to our membership. The meeting was held at the new Des Moines Art Center which recently opened. Members had the opportunity to view the large 19th and 20th century exhibit of paintings and sculpture until meeting time. Recommendations and actions of the House of Delegates were heard and discussed. Amendments to the state constitution were made. New officers and delegates were also elected. Program for the day included: "Welcome Address" by Mr. R. J. Hunt, Assistant Director of the Des Moines Art Center; "Ceramic Techniques and Potter's Wheel Demonstration" by William E. Ross,

Instructor of Ceramics at the Des Moines Art Center. The meeting was climaxed by a luncheon for 30 at Younkers Tea Room at which Dr. Charles C. Graves, Director of Iowa Mental Institution, was guest speaker.

OFFICERS

President: Miss Betty L. Lelene, O.T.R., Veterans Administration Hospital, Des Moines.

Vice President: Miss Barbara Jones, O.T.R., Cherokee State Hospital, Cherokee.

Secretary-Treasurer: Mrs. Elizabeth Green Mahon, O.T.R., Veterans Administration Hospital, Des Moines.

INDIANA

Delegate-Reporter, Evelyn Marsh, O.T.R.

The Indiana Occupational Therapy Association held five meetings during 1947-48. The first meeting was a dinner meeting at which the speaker was Dr. David A. Boyd, professor of neuro-psychiatry at Indiana University Medical Center. The topic was New Developments and Future Plans for Psychiatry in Indiana.

The second meeting was a business meeting at Riley Hospital at which the alternate delegate, Miss Edna Faeser of General Hospital, Indianapolis, gave a report of the National Convention, which had been held in California.

In January, Dr. James S. Browning, Attending Physician in Medicine at General Hospital, spoke on "Arthritis and Its Treatment" including both P.T. and O.T. as part of the medical team in the over-all treatment of the arthritic. This was a joint meeting at General Hospital with the Indiana Chapter of Physical Therapy.

The March meeting was held at the Cold Springs Road Veterans' Hospital and consisted of a business meeting and an exhibit of work done by the patients.

A picnic supper at Sunnyside Sanatorium provided the last meeting of the season. Following the picnic a business meeting was held at which each chairman gave a report of her committee and its activities for the year.

It was also decided that the publicity chairman should outline a program for contacting high schools and colleges to promote interest in O.T. and to recruit students for our O.T. schools by having the members of the Indiana Occupational Therapy Association speak before these groups, showing slides and movies of O.T. activities.

The Indiana Occupational Therapy Association was responsible for the O.T. Section Program at the annual Tri-State Hospital Assembly in Chicago in May. Miss Elizabeth Gallagher, O.T.R., Riley Hospital, Indianapolis, was the program chairman.

Joan McCord—Vice-President (Acting President, due to resignation of President).

Marion Kraker—Secretary.

Anita Slominski—Treasurer

Also, we are proud of the fact that Miss Edna Faeser has been elected the Speaker of the House of Delegates.

OREGON

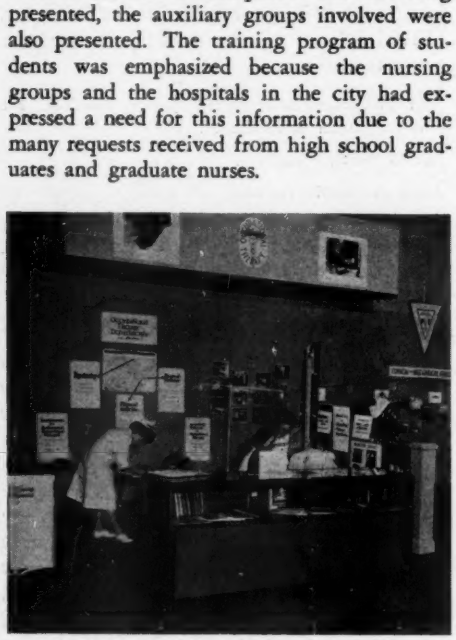
Delegate-Reporter, Caroline Haskins, O.T.R.

It is not every day that an Occupational Therapy Association has the opportunity to present information to the public with the faculty that was ours. By invitation of the Oregon State Nurses Association, District No. 1, the Occupational Therapists of Portland participated in a three-day program, "Nursing Serves You," in the Public Service Auditorium of the Meier and Frank Company. Through the interest and efforts of Miss Marjorie Joye, R.N., Chairman of the Publicity Committee, the Occupational Therapy and Physical Therapy booths were allocated the entire space at the end of the auditorium facing the rostrum. We felt that it was the best location obtainable, certainly affording the two groups excellent presentation of the allied fields. The Meier and Frank Company, which is the largest department store in Portland, furnished all labor for erection of booths and for the making of any posters or signs needed, and in addition they provided chairs, tables, showcases, as well as personnel to assist in arrangement where necessary. Mr. Chester Duncan, Personnel Representative of the Meier and Frank Company, collaborated with the committees in charge of the various aspects of the exhibit and personally supervised the work of the store staff throughout the exhibit. Anyone who has participated in a show of this size can appreciate how much this cooperation meant.

As this was the first public professional appearance of Occupational Therapy in Oregon, an effort was made to present an over-all picture of Occupational Therapy in Portland. Emphasis was placed on the educational and medi-

cal aspects of the work rather than on finished projects or the activities used.

As it was the Portland picture that was being presented, the auxiliary groups involved were also presented. The training program of students was emphasized because the nursing groups and the hospitals in the city had expressed a need for this information due to the many requests received from high school graduates and graduate nurses.



The general plan of the booth was altered a number of times to accommodate changing conditions but despite the necessity of eliminating some of the material at the last moment, we were able to utilize practically all of the original material. The space allotted was 20 feet back-wall space with division on sidewalls 4 feet high and 8 feet long, providing a booth 8′ x 20′. The back wall was a secondary plywood wall 9 feet high. Although a balcony protruded out over the O.T. booth this was utilized for the national insignia flanked by large photographs of patients working, sent by the University of Wisconsin. It was with regret that the rest of the excellent enlargements could not be used, but space did not permit. Centered on the back wall of the booth was a large outline map of the city of Portland which was loaned to us by the artist, Margarette Gillespie, for reproduction and enlargement. Located on this map were the three hospitals which have Occupational Therapy Departments and from these three points red tape extended out beyond the borders of the map to posters describing each hospital as to type and operating agent. The three departments are the Morningside Hospital, Veterans' Administration Hospital, and the University of Oregon Medical School Hospitals. Also occupying the back wall to the right of the map was a large group of photographs sent from the College of Puget Sound to graphically present the student training program. These photographs were arranged to show the theoretical and the clinical training programs. Two other posters presented the Accredited Schools of Occupational Therapy on the West Coast, and the requirements for a Professional Occupational Therapist. The entire left side of the booth was given over to a presentation of the toys for the different age levels by the Doernbecher Children's Hospital. The part of the nurse in the Pediatric Program was emphasized. The right wall presented the non professional organizations which assist in the Occupational Therapy Programs in the Portland hospitals. These included the American Red Cross Arts and Skills Corps, the Junior League of Portland, and the Library Association of Portland. Enough praise cannot be given to these groups for their cooperation. Each sent its own poster and the Red Cross set up a ward cart used in the hospitals showing the projects made by the veterans.

Within the booth a large tapestry frame was set up with a braid weave rug started, also a counter-balance suspension sling chair. It was felt that these would provide activity necessary for demonstration purposes as well as good "attention-getters." Note: they were! Tacked to the frame was a large poster—"It is not what the patient does to the material but what the material has done for the patient that is important."

At the entrance to the booth a floor stand held a poster outlining the teaching programs which are carried out by the various departments in the city. There was no attempt to feature any one O.T. Department but rather all the identities were merged into one picture.

Across the front of the booth was placed a long showcase in which were displayed the books from "An O.T.'s Library." The central portion was given over to the text-books on Occupational Therapy; the left end featured the books and magazines having to do with

the activities; the right end featured the medical books used for reference and teaching. Rehabilitation was included in this group.

It is impossible to evaluate this exhibit because there was so much that was intangible in the way of benefit. We felt that the original invitation by the Nursing Association was most generous but it has been overshadowed by their request that we join them in a similar exhibit next year. Every group which was approached for assistance responded readily and in a most friendly manner. In other words the interest and personal contacts seem to be the outstanding benefits at present. There is no doubt that a big step has been made for there was real interest shown by the lay visitors and by the professional groups exhibiting. What more could any of us want for a start?

* * * * *

Four regular meetings of the Oregon O.T. Association were held during the past year, with an average attendance of twelve per meeting. Programs were equally divided between business meetings and educational features.

OFFICERS

President: Mary Royce, O.T.R., Veterans Administration Hospital, Portland.

Vice President: Grace Black, O.T.R., University of Oregon Medical School, 3181 S.W. Marquan Hill Road, Portland.

Secretary: Shirley Bowing, O.T.R., National Society for Crippled Children and Adults, 1220 S.W. Morrison, Portland.

Treasurer: Betty Coulter, O.T.R., Veterans Administration Hospital, Roseburg, Oregon.

SPECIAL GROUPS

ARMY

ON ACTIVE DUTY

The following Occupational Therapists have been appointed second lieutenants in the Occupational Therapist Section, Women's Medical Specialist Corps. They are assigned to the following general hospitals for their initial tour of duty:

Name	*School*	*Assignment*
Andersland, Louise	University of Illinois	Tilton Gen. Hos.
Bastable, Ann Dwyer	Ohio State University	Percy Jones Gen. Hos.
Marcy, Mercedes	Univ. of So. Calif.	Letterman Gen. Hos.
Mueller, Elamay	Washington University	Fitzsimons Gen. Hos.
O'Neil, Margaret	Kansas University	Madigan Gen. Hos.
Pace, Helen	B. S. O.T.	Percy Jones Gen. Hos.
Pomeroy, Mary Ellen	Univ. of So. Calif.	Letterman Gen. Hos.
Sharp, Judith	San Jose State College	Murphy Gen. Hos.
Stockholm, Barbara	San Jose State College	Letterman Gen. Hos.
Styles, Jean	New York University	Fitzsimons Gen. Hos.
Vodopic, Mary Amelia	Kalamazoo University	Tilton Gen. Hos.

PUBLIC HEALTH SERVICE REGULATIONS EXCERPTS PERTAINING TO O.T.

SUBPART B—TITLES

§ 21.11 *Officers other than medical officers.* The titles of officers, other than medical officers, in the junior assistant, assistant, senior assistant, full, and senior grades shall be "therapist." The titles of officers, other than medical officers, in the director grade shall be the term "director" preceded by the term "therapist." The titles of officers, other than medical officers, in the grade of Assistant Surgeon General shall be "Assistant Surgeon General," execpt that following such title there shall added a parenthetical identification, such as *(occupational)* or *(physical)*.

§ 21.12 *Designation of specialties.* Scientist officers and other officers having generally descriptive titles, in using their titles in correspondence outside the Agency and in programs of scientific meetings, may designate their specialties in parenthesis following their names and titles, as, for example, Richard Roe, Senior Scientist (Entomologist). (Sec. 206 (b), 58 Stat. 685; 42 U. S. C. 207 (b))

§ 21.13 *Military titles.* An officer in uniform may use, for purposes of identification and address, the military or naval title of rank corresponding to the grade markings worn. An officer detailed for duty with the Army, Air Force, Navy, Coast Guard, or Coast and Geodetic Survey may use in official correspondence the title of military or naval rank corresponding to the grade markings worn, as, for example, Richard Roe, Major, U. S. P. H. S., or Richard Roe, Lieutenant Commander, U. S. P. H. S.

SUBPART C—APPOINTMENT

Provisions Applicable Both to Regular and Reserve Corps

§ 21.21 *Meaning of terms.* The term "approved" as used in this subpart in connection with "school," "col-

lege," "postgraduate school," or "training course" means, except as otherwise provided by law, a school, college, postgraduate school, or training course which has been accredited or approved by a professional body or bodies acceptable to the Surgeon General for such purpose, or which, in the absence of such a body, meets generally accepted professional standards as determined by the Surgeon General.

§ 21.22 *Submission of application and evidence of qualifications*—(a) *Application form.* Every candidate for examination for appointment as an officer shall submit a written application on such form as may be prescribed by the Surgeon General.

(b) *Documentary evidence and photograph.* The application shall be accompanied by: (1) Documentary evidence of (i) date and place of birth (birth certificate if obtainable); (ii) completion of educational and professional training; (iii) United States citizenship in the case of an applicant of foreign birth; and (iv) current registration as a graduate nurse under a nurse practice act of a State, Territory, or the District of Columbia in the case of a nurse; (2) such other documentary evidence as may be required by the Surgeon General, and (3) a recent photograph.

§ 21.24 *Physical examinations.* Every candidate for appointment as an officer shall undergo such physical examination as the Surgeon General may direct, and no candidate who is not found to be physically qualified shall be appointed as an officer.

§ 21.25 *Eligibility; junior assistant grade*—(a) *Requirements; all candidates.* Except as provided in § 21.54 and as otherwise provided in this section, every candidate for examination for appointment in the grade of junior assistant:

(1) Shall be a citizen of the United States;

(2) Shall be at least 18 years of age; and

(3) Shall have been granted an academic or professional degree from an approved school, college, or postgraduate school, and, unless the required professional training has been otherwise obtained from an approved school, college, or postgraduate school, shall have majored in the profession in which the examination is being held.

(c) *Special requirement; therapists.* Every candidate for examination for appointment as a therapist shall have received a certificate from an approved school of physical therapy or an approved school of occupational therapy.

(d) *Temporary substitute for academic or professional degree; nurse officers and therapists.* Every candidate who applies for examination for appointment as a nurse officer or therapist in the junior assistant grade prior to January 1, 1949, and who has received subsequent to July 1, 1943, a certificate in his profession from an approved school, may substitute such certificate for the requirement of academic or professional degree.

§ 21.26 *Eligibility; assistant grade*—(a) *Requirements; all candidates.* Except as otherwise provided in this section, every candidate for examination for appointment in the grade of assistant:

(1) Shall meet the requirements for eligibility for examination for appointment in the grade of junior assistant;

(2) Shall be at least 21 years of age; and

(3) Shall have had at least 7 years of educational and professional training or experience subsequent to high school, except that a candidate who applies for examination for appointment in the Reserve Corps to serve as a medical or dental intern may be examined for such appointment upon the completion of 6 years of such education, training, or experience.

(c) *Temporary substitute for academic degree; nurse officers and therapists.* Every candidate who has received subsequent to July 1, 1943, a certificate in his profession from an approved school, who applies for examination for appointment as a nurse officer or therapist in the assistant grade prior to January 1, 1953, and who has had, during the five years immediately prior to the date of such application, 4 years or more of experience as a nurse, physical therapist, or occupational therapist in the Army, Navy, or Public Health Service with a satisfactory record of active service, may substitute such certificate and experience for the requirement of an academic degree.

§ 21.27 *Eligibility; senior assistant grade.* Every candidate for examination for appointment in the grade of senior assistant shall meet the requirements for eligibility for examination for appointment in the grade of assistant and shall have completed at least 10 years of educational and professional training or experience subsequent to high school.

§ 21.29 *Eligibility; all grades; academic and professional education and professional training and experience.* The Surgeon General is authorized, subject to the other provisions of this subpart, to adopt additional standards by which the education, training, and experience required under this subpart, and evidence thereof, shall be of such specific kind and quality, pertinent to the particular profession concerned, as in his judgment are necessary to limit the examination to qualified candidates.

Leave with Pay

§ 21.84 *Accrual and accumulation of annual leave.* An officer shall accrue annual leave at the rate of 30 days for each full year of active service with the Service, and for any portion of a year at the rate of one day for each 12 consecutive days of such service. Annual leave accrued during a leave year, but unused at the end of such year, shall be carried forward as accumulated leave for use in succeeding leave years, except that accumulated leave credited to an officer at the beginning of a new leave year in excess of 60 days shall be canceled.

Application for a Commission, Regular or Reserve, should be made to the Surgeon General, U. S. Public Health Service, Washington 25, D. C.

Pay scale for commissioned members of the Regular and/or Reserve Corps is as follows:

Equivalent Grade	*Base Pay*	*Subsistence*	*Total*
Jr. Asst. Therapist (2nd Lt., Ensign)	$2,160	$ 795.50	$2,955.50
Asst. Therapist (1st Lt., Lt. j.g.)	2,400	975.50	3,375.50
Sr. Asst. Therapist (Capt. or Lt.)	2,898	1,155.50	3,915.50
Full Grade Therapist (Maj. or Lt. Commdr.)	3,795	1,335.50	4,635.50

A retirement deduction of 6% applies to base pay only of Reserve Officers. No deduction applies to Regular Officers.

COMMITTEE REPORTS

REPORT OF THE EDUCATION COMMITTEE

September 6, 1948

During the past year the following schools have been given tentative approval pending inspection visits by the officials of the American Medical Association:

University of Minnesota
University of Iowa
Wayne University, Detroit

The only new school which is not yet ready for final approval is Colorado College of Agriculture and Mechanic Arts.

Inquiries have been received regarding the possibility of opening another school in the University of California at Los Angeles, in Alverno College, Milwaukee, Wisconsin, and in Puerto Rico. There may be interest in starting one or two more schools in the South and Southeast, but no action has been taken.

The Education Committee now functions, with a chairman and two vice-chairmen representing the three main sections of the country, as a central committee with a total membership of fourteen. Five of the members represent the schools and five clinical training centers geographically distributed. These members and five alternates from each sub-committee (Schools and Curriculum and Clinical Training) are elected by their respective committees.

The Sub-Committee on Schools and Curriculum (Miss Beatrice Wade, Chairman), besides serving as a forum for general discussion of school problems, has been conducting two special projects. A committee, of which Miss Martha Jackson has been chairman, has made a survey of the demand and opportunity for graduate study. The results will be published in AJOT. Miss Henrietta McNary and her committee on Curriculum Guide have continued work on this project.

Attention is being given to such problems as terminology, credit allotment and course sequence, reciprocity with foreign schools, the question of accepting positions in Osteopathic hospitals, the training of therapists in music and recreation, the official listing of degrees granted by accredited schools and the possibility of an honorary society for occupational and physical therapists.

The Sub-Committee on Clinical Training, Miss Margaret Gleave, Chairman, has done an outstanding piece of work on the rater's guide and interpretational key which is now in use in clinical training centers throughout the country.

Four projects are at present under way:

1. A student manual for clinical training which is the corrollary of the director's manual.
   Committee: Elizabeth Collins, Margaret Blodgett, Jane Merrill.
2. The establishment of a pool for use by both schools and clinical training centers in placement of students for clinical training.
   Committee: Edna Faeser, Ruth Grummon.
3. The evaluation and accrediting of clinical training centers.
   Committee: Clare Spackman, Elizabeth Messick, Naida Ackley, Alice Letchworth.
4. The yearly evaluation of clinical training programs by schools and vice versa based on the immediate reactions of students and directors.
   Committee: Carlotta Welles, Mary Berteling.

The Education Committee per se has been working on the American Medical Association essentials for occupational therapy schools after recommendations have been made by the two sub-committees.

The Board approved a recommendation that the clinical training period should be not less than nine months and that no student should be assigned to any one clinical training center for less than eight weeks.

The Committee is also giving careful consideration to the relationship between occupational therapy and physical medicine. This is definitely a matter of major concern as it may seriously affect the whole status of occupational therapy.

Thanks are due to the committee chairmen who have guided the progress of the past year and to the members of their committees who have worked long and hard on their various tasks.

HELEN S. WILLARD
Chairman, Education Committee

Worn brushes can be reshaped, or special ones made to suit the job to be done. Soak the bristles in water soluble glue, shape to a compact mass and let dry. Then rub on coarse abrasive paper to the form desired. Remove the glue in hot water.

Treasurer's Report for Sep. 1, 1947 to Aug. 31, 1948

The financial statement for the fiscal year, September 1, 1946—August 31, 1947, and the estimated budget for September 1, 1947—August 31, 1948, were presented and approved by the House of Delegates and the Board of Management, and published in the December 1948 issue of AJOT. This report presents the actual receipts and expenditures for the year 1947-48 and the proposed budget for the period from September 1, 1948—August 31, 1949.

There are certain pertinent facts which should be called to your attention. For the last few years we have experienced a rapid growth in our membership. For example, our receipts from membership dues have increased from $8,873 in 1943 to $19,444 in 1948. A similar increase is shown in registration fees. This occurred mainly during the war years. This increase in revenue has made possible our expanded program, which has been materially assisted by the generous grant of the Kellogg Foundation. With the return to peacetime we have come to a plateau. How has this affected this year's finances? We had estimated a total income of $37,000 from membership dues and registration. If all last year's members had paid their dues we would have received $39,000. Actually, we fell approximately $7,000 short in revenue.

What has this meant to the membership?

1. Publicity has had to be curtailed. It has been impossible in some instances to send representatives to allied professional meetings or to afford to have a special exhibit. This has been made up to a certain extent by the cooperation of local groups, but that is not an entirely satisfactory solution as many heads of occupational therapy departments have been asked to spare members of their staffs to man such exhibits, and it has been impossible to pay railroad fares or contribute to expenses. We should have the needed money to carry out adequate professional cooperation with other organizations. Until we do we must not be surprised if our profession fails to receive adequate recognition.

2. That Placement Service has not been expanded as had been planned. We all know that this is of vital importance to you personally as occupational therapists and to the development of our profession.

3. The work of our committees which are the lifeblood of our Association has necessarily been limited because it was impossible to offer carfare even in part to the members. This bars us from the services of those who are too isolated to come together with the groups working throughout the country. Special tribute should be paid to those who do serve faithfully on our committees, contributing much not only intellectually but financially.

4. The rising cost of prices and wages has necessitated the reduction of the A.O.T.A. office staff in order to balance the budget. This has meant less service to you and to your profession in spite of the very valiant efforts of the present staff. Miss West has balanced the deficit budget by cutting the planned expenditures $7,000. To her careful business management we owe the fact that we are solvent.

What of the future? That depends on you. What do you want from your Association? What do you want for your profession? What can you do to get these?

1. Pay registration fees, $5.00—membership dues, $8.00—total $13.00, immediately on receipt of the bill. During this year more than half of the payments came in four months or more late. We know that some persons undoubtedly failed to receive a bill because of incorrect addresses. If this occurs won't you let us hear from you?

Three things happen when dues are late:

1. We do not know how many issues of AJOT to publish.

2. The directory of registered O.T.'s is late and as a result inaccurate.

3. We do not know how much money is available to operate the Association.

These problems have been discussed at length in both the House of Delegates and the Board. The following plan has been adopted:

1. The bill for 1949 re-registration fee, $5.00, and the A.O.T.A. dues $8.00 — total $13.00, will be sent out in the fall. You will have until December 31, 1948 to pay this. (We hope you will pay it as soon as you receive it.) If by January 1, 1949 you have not

paid it you will receive a second bill, giving you until January 31, 1949 to pay. At that time if you have not paid you will not be listed in the 1949 Registry, which we hope to have ready by March, 1949; nor will you receive AJOT. Should you pay your dues to the A.O.T.A. at a later date we cannot guarantee the back issues of AJOT already sent in 1949. It is requested that those who do not wish to remain as active members should resign from the Association.

Such an arrangement should enable us to ascertain promptly how much money we have to use to promote your profession and your welfare.

Many of you offer constructive ideas for activities and services to be carried out by the A.O.T.A. These can only be accomplished with adequate funds, the provision of which is the personal and moral obligation of every member of the A.O.T.A.

American Occupational Therapy Association

Tentative Budget—Income and Expenses
September 1, 1948—August 31, 1949

GENERAL FUND

	BUDGET 1947-1948	Bal. 9/1/47	Total Receipts 1947-1948	BUDGET 1948-1949
INCOME:				
Membership dues	$21,000.00		19,444.00	$21,000.00
Registration fees	16,000.00		12,964.00	14,000.00
Subscription to A.J.O.T.	500.00		325.70	300.00
Volunteer Course	75.00		106.00	100.00
Sales — Insignia, Pins, Reprints	3,100.00		1,511.73	1,500.00
Yearbook Sales	200.00		252.60	200.00
Yearbook Advertising	700.00		42.50	500.00
Donations	200.00		150.25	150.00
Miscellaneous	100.00		50.00	50.00
TOTAL INCOME	$41,875.00		$36,902.74	$37,800.00
EXPENSES:				
Administration	$ 2,100.00		$ 1,488.26	$ 1,500.00
Publicity	5,000,00		2,291.81	2,300.00
Placement	3,500.00		2,448.05	2,600.00
Publication and expenses	7,000.00		12,650.94	13,000.00
Registration and Membership	10,000.00		6,932.33	9,700.00
Examination	——		314.54	——
Service for Committees	5,500.00		5,401.35	6,000.00
Co-operation with other Agencies	60.00		309.13	400.00
Material for Re-sale	2,500.00		1,775.31	2,000.00
Volunteer Course	100.00		62.22	100.00
Taxes Withheld	——		355.27	200.00
Grant to Educational Program	3,000.00		——	——
TOTAL EXPENSES	38,760.00		34,029.21	37,800.00
Cash Reserve	3,115.00		2,873.53	——
	$41,875.00		$36,902.74	$37,800.00

EDUCATIONAL FUND

	BUDGET 1947-1948	Bal. 9/1/47	Total Receipts 1947-1948	BUDGET 1948-1949
INCOME:				
Kellogg Grant	$ 7,000.00		7,000.00	$10,000.00
Examination fees	4,000.00		5,040.00	3,770.00
General Fund, A.O.T.A.	3,000.00		——	——
Reprints sold	——		53.40	——
Institute — Conv.	——		537.50	——
Miscellaneous	——		55.04	——
TOTAL INCOME	$14,000.00		$13,046.48	$13,770.00
EXPENSES:				
Salaries—EDS & Sec.	$ 6,340.00		$ 4,683.43	$ 6,340.00
Consultant's fee	2,500.00		1,889.00	2,500.00
Examination expense	——		534.61	500.00
Postage & Express	400.00		262.33	400.00
Office Supplies	325.00		158.27	250.00
Travel	840.00		416.53	800.00
Telephone & Telegraph	400.00		254.85	300.00
Printing	800.00		383.40	500.00
Rent & Light	780.00		780.00	780.00
Office Repairs	100.00		20.16	75.00
Taxes Withheld (Misc.)	140.00		155.50	100.00
Audit	75.00		90.00	100.00
Unemployment Ins.	250.00		125.15	175.00
Furniture & Fixtures	700.00		866.16	100.00
Computations	350.00		285.00	350.00
Institute — Conv.	——		484.53	——
Reprints Purchased	——		133.93	——
Special Account	——		323.50	——
TOTAL EXPENSES	14,000.00		11,846.35	13,270.00
Cash Reserve	——		1,200.13	500.00
	$14,000.00		$13,046.48	$13,770.00

EXPENDITURES

Payroll—		
A.O.T.A. Office	$12,336.52	
A.J.O.T. Office Editor	1,333.28	$13,669.80
Co-operation with other agencies	——	309.13
Exhibit (Ed. Publicity)		350.00
Printing		1,919.39
Travel		247.28
Supplies		652.21
Postage & Express		830.69
Bonding		16.39

Telephone & Telegraph		539.77
Rent & Light		1,865.04
Office Repair		18.50
Stencils		67.68
Unemployment		331.75
Consultants Fee		264.00
Audit—		
A.O.T.A. Office	$ 160.00	
A.J.O.T. Office	190.31	350.31
Legal—A.J.O.T. office		75.00
A.J.O.T. Expense		1,331.71
A.J.O.T. Subscriptions		7,791.00
Insignia Purchased		364.04
Pins Purchased		129.00
Reprints purchased—		
To sell	$ 496.92	
For free—printed matter	639.51	1,136.43
Furniture & Fixtures—		
Typewriter	$ 160.38	
Card Wheel	18.05	178.43
Convention Expenses—		
1947	$ 526.71	
1948	525.65	1,052.36
Volunteer—Free material		62.22
Taxes—Withheld and S. S.		355.27
Miscellaneous—Bank Fees, Bldg. gratuities etc.		121.81
Total Expenses—Sept. 1st, 1947 to Aug. 31st, 1948		$34,029.21

MINUTES OF THE MEETINGS OF THE HOUSE OF DELEGATES

September 5 and 6, 1948

Hotel Pennsylvania, New York City

The meeting was called to order by the Speaker, Mrs. Harriet Tiebel. The Secretary, Miss Edna-Ellen Bell, took the roll. Those present were:

Association	*Delegate*
Calif., Northern	Meryl Van Vlack
	Alternate, Louise Burton
Calif., Southern	Carlotta Welles
	Alternate, Lucy Potter
Colorado	Josephine Davis
Connecticut	Bertha J. Piper
	Alternate, Ruth Kensey
Dist. of Col.	Violet Corliss
Hawaii	Esther Pyun
Illinois	Angelina Howard
	Alternate, Ella Fay
Indiana	Edna Faeser
Iowa	Maxine Ferrell
Kansas	Nancy Greenman
Kentucky	Nell McCulloch
Maryland	Eleanor Owen
Massachusetts	Elizabeth Collins
Michigan	Marion R. Spear
Minnesota	Borghild Hansen
Missouri	Dorothy Flint
N. E., Northern	Doris Wilkins
New Jersey	Naida Ackley
	Alternate, Gail Fidler
New York	Harriet J. Tiebel
	Alternate, Blanche M. Ringel
N. Y., Western	Cornelia Smith
	Alternate, Theresa Pratt
Ohio	Minnie Fevold
Oregon	Caroline Haskins
Pennsylvania	Eleanor Randall
Texas	Lenore Brannon

Virginia	Mary Junkin
Washington	Edna-Ellen Bell
	Alternate, Alice M. Hussey
Wisconsin	Janice Olson

Western Pennsylvania was the only state association not represented.

The Speaker appointed a nominating committee consisting of Borghild Hanson, Chairman, Dorothy Flint and Naida Ackley.

There were no new state or regional associations applying for admission to the House.

Mrs. Kahmann greeted members of the House, followed by a report from the Executive Director. Miss West discussed the work of the National Office, including services to members, placement service, public relations and membership figures. Miss Eva Otto reported on the work of the Education Office. The report of the Treasurer was presented by Miss Spackman, with a layman's summary of expenses and receipts of the A.O.T.A. She answered questions about individual items on the budget and discussed the needs of the National Office for personnel and the difficulties involved when dues and registration fees are not paid. A motion was made by Miss Corliss and passed that A.O.T.A. bills payable January 1st be sent as soon as possible; that a second notice be sent on January 1st to those who have not paid by that date; that those still delinquent on January 31st will not receive A.J.O.T. until their dues have been paid and their names will not appear in the 1949 Registry. This recommendation was later presented to the Board and accepted for action by the Board.

The editor of A.J.O.T., Miss Carlotte Bone, reported on production costs of A.J.O.T. and comparisons with the Archives of Physical Medicine and the Physical Therapy Review. Delegates were requested to refer to the editor of A.J.O.T. local merchandisers who might consider advertising in A.J.O.T. Delegates were asked for assistance in collecting local news, volunteer reports, unsolicited manuscripts (for better selection and quality in the magazine) and names of persons for articles on clinical training needs. State association reports will be printed approximately every two years.

The chairman of the Subcommittee on Clinical Training, Miss Margaret Gleave, reported on the Rating Form and Interpretational Key which will finish its year's trial on January 1, 1949, and on the Clinical Training Pool which is being established to facilitate the placement of students for clinical training affiliations and to assist in maintaining continuity in the schedules of the clinical training centers. She emphasized that no secret key is to be used in connection with the rating form and key. Miss Gleave spoke of the accrediting of clinical training centers and of the experimental self-evaluation plan which is to go to fifty training centers selected at random in ten areas.

The Committee on Credentials reported on state and regional association constitutions. Seven states did not send 1948 corrected constitutions. Three states did not revise their constitutions as directed by the Committee and the House. Recommendations were made by the Committee on Credentials and the following motions passed:

1. A motion was made by Miss Ackley and passed that when a delegate of an association is delinquent in fulfilling her duties to the House, the Committee on Credentials should take steps to investigate the situation; that after the delinquency has existed for one year the local association should be informed that its delegate will no longer be recognized and that it will be necessary to elect a new delegate if the association wishes to continue its affiliation with the House. If a new delegate is not elected, by a vote of the House, the affiliation will be ended and the association can be readmitted only upon formal application to the Secretary of the House.
2. A motion was made by Miss Faeser and passed that if a state or regional association has not within one year complied with the recommendations of the Committee on Credentials regarding revision of its constitution, that association may, by action of the House, be deprived of its vote and active participation in the House until the requirements for affiliation have been fulfilled.
3. A motion was made by Miss Bell and passed that the alternate delegate, as well as the delegate, be elected.
4. A motion was made by Miss Howard and passed that a delegate be eligible for election as a House officer or delegate Board member at the end of the first session of the House of Delegates at which she serves. This will enable delegates to serve a complete two-year term as delegate Board members or two consecutive year terms as House Officers.
5. Miss Bell made a motion, which was carried, that the status of alternates serving for the delegates be clarified by the state associations at the time the credentials are sent to the Secretary of the House; that whenever possible, when a delegate or alternate delegate cannot attend a meeting of the House, a new delegate or alternate be duly elected.
6. A motion was made by Miss Bell and passed that alternates attending the House meetings be permitted to participate in the discussion.
7. The motion was made and passed that if the alternates for the Speaker and the Secretary of the House are present, they be permitted to vote for these officers. This will save time and confusion in House sessions.

A suggestion was made and it was the consensus of the House that the Speaker send the tentative agenda for the next meeting of the House to the Delegates in time for the spring state association meetings.

The delegates were asked to compile lists of all hos-

pitals and institutions in their areas which employ registered occupational therapists, to be sent to the National Office.

Names for the Medallion of Honor awards to be made by the Women's International Exposition were collected from each delegate for tabulation. A brief write-up of the "Ideal Career Girl" proposed by each state association was given to the Speaker.

A motion was made by Miss Bell that the delegate hold no other office in a state or regional association. After discussion, this was referred to the state associations for further discussion, to be voted on at the next House meeting.

Holding two House meetings a year was discussed and referred to state associations for discussion there, to be voted on at the next House session. Since the purpose of holding a second House meeting during the year is to discuss the business before the Association, the House passed a recommendation to the Board of Management that the agenda of the March Board meeting be sent to the delegates in time for the delegates to instruct their delegate Board members on the matters on the agenda. The Board later accepted this recommendation.

Future conventions were discussed, with Mrs. Murphy present to report informally on plans of the Permanent Convention Committee. A majority of the House voted in favor of alternating formal and informal types of meetings, with American plan hotels preferred. The time for conventions was discussed; the majority of the delegates preferred late October or early November to August. A motion was made by Miss Bell and passed that the month of March as a permanent convention date be considered by the state associations and placed on the agenda for the next House meeting.

A.O.T.A. representation at other professional meetings and in other organizations was discussed. The House passed the recommendation to the Board that a list of previous professional affiliations be published, that a list of the representation we now have be published and that we seek ways of gaining representation that we do not now have. The Board later accepted the recommendation that a list of our present affiliations with other organizations be compiled. This list will be sent to the delegates for the information of members in the local associations. The House was reminded that lack of funds prevents sending A.O.T.A. representatives to many meetings at which representation is requested. The Board requested the delegates to keep the A.O.T.A. informed regarding affiliations with other groups which have been made by local associations.

A recommendation to the Board was made and passed that when an A.O.T.A. representative is unable to attend a scheduled meeting of an allied group, a local member in that area be appointed to officially represent the A.O.T.A. Upon receiving this recommendation, the Board replied that arrangements for complying with it had already been made and acted upon on previous occasions.

A motion was made by Miss Bell, amended by Mrs. Fidler, that the delegates take to their associations for discussion:

1. Proportional representation in the House of Delegates, based upon paid-up memberships.
2. Equal representation on the Board of Management
   a. One member from each association
   b. One member from each of the special fields of Occupational Therapy. (Psychiatry, Tuberculosis, Orthopedics, Pediatrics, etc.)

Placement service in the National Office was discussed and a recommendation to the Board was passed requesting that the Executive Director continue to investigate the methods of expanding the scope of the placement service. The delegates were of the opinion that the members of the Association would be willing to pay for such a service, whether administered by the National Office or by an established placement bureau approved by the A.O.T.A. The decision of the Board was that the placement service will be continued by the National Office and will be administered as efficiently as existing personnel permits. In addition, the editor of A.J.O.T. has been authorized by the Board to accept listings from registered occupational therapists seeking jobs and from institutions seeking qualified staff members. The fee to be charged will be in accordance with

LUCIE MURPHY TO ASSUME EDITORSHIP OF JOURNAL

Mrs. Lucie Spence Murphy, O.T.R., 1313 E. Elmdale Court, Milwaukee 11, Wisconsin, assumes the post of managing editor of the *Journal* on January 1, 1949. All material pertaining to the publication should be sent to her at the above address.

Production of the *Journal*, beginning with the February 1949 issue, will be carried out under her direction at Calumet Publishing Co., 9120 Baltimore, Chicago 17, Illinois.

The outgoing editor, having experienced both professionally and personally the impetus which can be provided the *Journal* by an interested, responsive and cooperative membership, sincerely requests that her successor be extended continuing encouragement and assistance.

current charges in similar publications. The Board does not approve affiliation with an outside placement bureau.

The agenda was interrupted so that the House might give its attention to a report by Miss Willard, Chairman of the Education Committee, on the statement of policy of the A.O.T.A. which has been formulated by this committee. Following this report a motion was made by Miss Collins and passed that this statement of policy be accepted with the unanimous approval of the House.

A motion was made by Miss Bell and passed that there be a final meeting of the House of Delegates following the final Board meeting, to be scheduled tentatively for 8:00 a.m. on September 10th.

Following discussion of the proposal to move the National Office to Chicago with the American Physical Therapy Association, a motion was made by Miss Bell and passed that we not move into joint offices with the A.P.T.A. or with any other closely allied group and that we carefully guard our own identity when we do move the National Office. Together with this expression to the Board, the House also asked if there has been any action on the proposal made by Dr. Westmoreland at the March Board meeting that building space might be available with either the American Medical Association or the American College of Surgeons. The Board later replied that it is not feasible to move the National Office at this time. Since this is the case, no definite commitments regarding office space can be made now. Dr. Westmoreland, a committee in Chicago and the officers of the A.O.T.A. have been investigating possible locations but it is impossible to rent office space which might possibly be occupied two or three years from now. Regarding sharing office space with the A.P.T.A., it is not the intention of the Association to share the same or joint offices, but that both associations move at approximately the same time and occupy separate offices located in close proximity to each other.

On the question of life membership, a motion was made by Miss Faeser and passed that in order to provide a basis for discussion of the matter by the House, the Speaker of the House appoint a committee to investigate life memberships in other organizations and to formulate plans for life membership in the A.O.T.A.

A motion made by Miss Bell was passed that the Board be requested to supply further information to the House concerning the granting of reciprocity to foreign trained therapists. The Board referred this request to the Registration Committee for study and recommendations.

The House passed a recommendation to the Board that the status of therapists who have passed the registration examination but have never held a position be clarified. The Board's attention was called to the wording of the A.O.T.A. Constitution (Article II, Section I) which defines active members as "registered occupational therapists who are or have been actively engaged in the use of Occupational Therapy." The Board referred this matter to the Constitution Committee, to be appointed.

The possibility that the secretaries of the state associations serve as local reporters for A.J.O.T. was discussed but no action was taken. It was decided that the delegates shall continue to carry the responsibility for securing and reporting news of their state associations.

A motion was made by Miss Hanson and passed that subscriptions to A.J.O.T. for Fellows of the Association be charged to the A.O.T.A. rather than to the local associations, as this would seem to be a matter of national rather than of local benefit. This action was in reference to the proposal by the Board in March, 1948, that A.J.O.T. subscription fees for Fellows be paid by the regional association of the state which they represent. No action was taken by the Board on this recommendation.

Reports were received from a number of delegates of state associations in the area of publicity. Effective local publicity was reported by the delegates from Missouri and Washington. Miss Junkin of Virginia had a scrapbook to show the delegates of publicity carried on there. The House was informed that the Society of Visual Education in Chicago has a slide film, "Occupational Therapy and Laboratory Technique as a Career," in their Vocational Guidance Department. It was suggested that such publicity as the states might find successful would be suitable to include in the local association reports in the Delegates Division of A.J.O.T. The House discussed the question of whether some form of national approval ought to be required when individual therapists submit articles to national publications other than A.J.O.T. The House referred this to the Board for an opinion. The Board sent back word to the House that such a requirement would be an infringement upon the right of freedom of speech.

Department planning, terminology and personnel policies were discussed by the members of the House. The matter of uniform terminology is being studied by a special subcommittee. Department planning, personnel policies and employment conditions are to be studied by a new special committee to be appointed by the President of the Association.

Military status of male occupational therapists was discussed. It was the consensus of the House that too small a number is involved to interest the Army in setting up a Men's Medical Specialty Corps. No further inquiry was suggested and no action taken.

The House recommended that the new special committee on personnel policies consider preparing material for publication in A.J.O.T. aimed toward encouraging a more liberal attitude on the part of hospital administrators toward granting time for attending professional meetings and serving on committees. The Board later accepted this recommendation for referral to the new committee.

Miss Welles reported on a request from the Southern California association for consideration of recognition of auxiliary workers or aides in occupational therapy departments, with listings in a secondary register, placement service, special insignia and refresher courses in Occupational Therapy. This request is being handled by the Education Committee with special reference to terminology involved.

House elections were held, with the following results:
Speaker of the House of Delegates—Miss Edna Faeser
Vice-Speaker of the House—Miss Josephine Davis
Secretary of the House—Miss Elizabeth Collins
Delegate Members of the Board of Management—
Miss Edna Faeser
Miss N. Meryl Van Vlack
Miss Doris Wilkins
The meeting adjourned.

By action of the House a final meeting of the House was held following the final Board meeting. Board actions on House recommendations were reported by Miss Faeser, the newly elected Speaker. Board actions on House recommendations have been indicated in the above minutes with discussion of each recommendation.

The President, Mrs. Kahman, spoke to the delegates regarding the affairs of the A.O.T.A., particularly the financial situation. She urged that each delegate assume the responsibility of interpreting these matters to the state and regional associations and of encouraging the active and loyal support of every member of the A.O.T.A.

Miss Faeser reported on plans for the next Registry and on the scope of the public relations carried on by the National Office during the past year.

The delegates were asked to interpret to local association members the difference between A.J.O.T. and O.T. & R. Many members apparently do not know that A.J.O.T. is the official publication of the A.O.T.A. The delegates were also asked to promote new subscriptions for A.J.O.T.

The delegates were asked to inform members of the local associations that a commercial exhibit is being planned in connection with next year's annual convention. Names and addresses of Supply and Equipment Companies who might be prospective exhibitors should be sent to Mrs. Murphy, chairman of the Permanent Convention Committee.

The Rules and Procedures Committee requested that each delegate prepare a list of members in her local association who are capable, willing and available for active participation on national committees. These lists are to be sent to Mrs. Kahmann. Special interests or capabilities should be included.

Following tabulation of House suggestions for the Medallion of Honor awards to be given by the Women's National Institute in New York City in November, the candidates were announced by the Board of Management to be: Mrs. Winifred Kahmann, Miss Sue Hurt, Miss Majorie Taylor, Miss Helen Willard. The "Ideal Career Girl" chosen is Lt. Mildred Bond.

The special meeting was adjourned.

Harriet J. Tiebel, O.T.R.
Retiring Speaker, House of Delegates

1948 WOMEN OF ACHIEVEMENT

On Nov. 1, in a colorful ceremony, handsome bronze medallions of honor were awarded by the Women's International Exposition, New York, to the following distinguished occupational therapists.

Miss Marjorie Taylor, O.T.R., of Milwaukee, Wis., Reconstruction Aide, O.T., in World War I, Member, Federal Advisory Council on Rehabilitation, the Baruch Committee on Physical Medicine, the National Society for Crippled Children, the American Hospital Association and the Committee on the Severely Handicapped, U. S. Dept. of Labor.

Mrs. Winifred C. Kahmann, O.T.R., President of the American Occupational Therapy Association, formerly Chief of the Occupational Therapy Branch, office of the Surgeon General, U. S. Army, and Member, the Professional Advisory Foundation for Infantile Paralysis.

Miss Helen S. Willard, O.T.R., Director of the Philadelphia School of Occupational Therapy, and Past President, Association of O.T. and P.T. Aides, of the Veterans Administration and of the Illinois O.T. Association.

Miss Sue Plummer Hurt, O.T.R., Chairman, A.O.T.A. Special Committee on Poliomyelitis, Major in the Army Reserve, Women's Medical Specialists Corps, Occupational Therapy Section.

These awards are bestowed annually upon different professional groups, honoring outstanding individuals, and dramatizing to the public advances made in the selected field.

A. P. A.

The 105th Annual Meeting of the American Psychiatric Association will be held in Montreal, Canada, from May 23 to May 27, 1949.

The Windsor Hotel will be headquarters, and arrangements have been made with the leading hotels in Montreal to house the necessary members and guests who plan to attend.

For hotel reservations, write to:

Mr. Paul E. Joubert
Montreal Tourist and Convention Bureau
1010 St. Catherine Street, W.
Montreal 2, Canada

Selected List of Motion Pictures on Rehabilitation and Physical Medicine

By HOWARD A. RUSK, M.D., *Professor and Chairman,* AND EUGENE J. TAYLOR
Department of Rehabilitation and Physical Medicine,
New York University College of Medicine
with the assistance of Miss Howardine McAteer and the New York Junior League

This bibliography of films in rehabilitation and physical medicine resulted from a weekly Film Forum held during 1947-1948 for the residents, students and staff of the Department of Rehabilitation and Physical Medicine at Bellevue Hospital in which a number of motion pictures were reviewed and evaluated. The bibliography does not include all of the films available in this field; some films were not included because they were considered obsolete or of minimal value; others have not as yet been reviewed. During 1948-49, the professional films listed will be used for training of students and personnel. A number of the "patient" films will be used for patient indoctrination and training as a regular scheduled part of their rehabilitation.

ACCENT ON USE (20', B & W, Sound). Shows the uses of physical therapy in the prevention of deformity and the rehabilitation of the physically disabled. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* NFIP.

AIDS IN MUSCLE TRAINING (10', B & W, Silent). Issued in 1938 by the Council on Physical Medicine of the American Medical Association. Demonstrates use of sling suspension exercises and walkers as applied to muscle re-education. *Suitability:* Physicians, therapists. *Quality:* Fair. *Source:* AMA.

AMPUTATION PROSTHESES AND THEIR USE: Part I. UPPER EXTREMITY (29', B & W, Sound: USA PMF 5024 MF 1262) Shows the making and fitting of prostheses, and training of patients in their use. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* USA.

AMPUTATION PROSTHESES AND THEIR USE: Part II. LOWER EXTREMITY (39', B & W, Sound; USA PMF 5025 MF 1263) As titled. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* USA.

BACK TO BATTLE (22', B & W, Sound). The use of rehabilitation and physical medicine in the restoration of Canadian battle casualties. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* National Film Board of Canada, 620 Fifth Ave., New York 20, N. Y.

BACK TO NORMAL (15', B & W, Sound). Produced by the British Information Services: illustrates the rehabilitation of amputees both military and civilian. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* AMA, NYU.

BELOW THE KNEE AMPUTATION (13', Color, Sound, USA PMF 5031 Misc. 1271). Pre- and post-operative management of B-K amputation. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* USA.

BLIND WORKERS IN PRIVATE INDUSTRY (15', Color, Sound). Shows selective placement of the blind. *Suitability:* Therapists, ancillary personnel. *Quality:* Good. *Source:* National Society for the Blind, 727 Woodward Building, Washington, D. C.

THE CINEPLASTIC OPERATION (20', Color, Sound, USA PMF 5062, Misc. 1320). As titled. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* USA.

COMEBACK (26', Color, Sound). Shows vocational rehabilitation for civilians. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* Available in each state through the State Division of Vocational Rehabilitation, or from Office of Vocational Rehabilitation, Federal Security Agency, Washington 25, D.C.

COMPLICATED AMPUTATIONS — CASE REPORTS (52', B & W, Sound, USA PMF 5026, Misc. 1264). Skull perforation, cranioplasty with tantalum plate; triple amputation with hemiplegia. *Suitability:* Physicians. *Quality:* Good. *Source:* USA.

CONDITION IMPROVED (40', B & W, Sound). Produced by the National Film Board of Canada; illustrates use of occupational therapy with war and civilian casualties. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* National Film Board of Canada, 620 Fifth Avenue, New York 20, N. Y.

CONQUERING DARKNESS (20', B & W, Sound). Demonstrates methods of training for the blind. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* New Jersey State Commission for the Blind, 1060 Broad Street, Newark 2, New Jersey.

THE CONTROL OF VOLUNTARY MUSCLES—SOME PRINCIPLES OF KINESIOLOGY (15', Color, Silent). A demonstration of the voluntary control of muscles. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* Northwestern University Medical School, 303 East Chicago Avenue, Chicago, Illinois.

CONVALESCENT CARE AND REHABILITATION OF PATIENTS WITH INJURY TO THE SPINAL CORD (41', Color. Sound, USA PMF 5015 MF1234). Approved diagnostic, surgical, nursing and physical medicine techniques and practices for care and rehabilitation of paraplegic patients. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* USA.

DIARY OF A SERGEANT (21', B & W, Sound, USA Misc. 1129). The psychological, physical and vocational rehabilitation of a bilateral, upper-extremity amputee (Harold Russell). *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Excellent. *Source:* USA.

THE DIODE (17', B & W, Sound, OE 176). Produced by the U. S. Office of Education; explains principles of the flow of electron across a gap, the diode tube, photoelectric cells, X-ray tubes and the diode as a rectifier. *Suitability:* Physicians, therapists. *Quality:* Good. Source: AMA.

EFFECTS OF MASSAGE ON CIRCULATION OF THE BLOOD (10', B & W, Silent). Shows the effect of massage on the circulation demonstrated through a glass chamber in a rabbit's ear. Interesting material, but insufficiently titled. *Suitability:* Physicians, therapists. *Quality:* Fair. *Source:* AMA.

ELECTRICAL REACTIONS IN MYOTONIA (12', B & W, Silent). Demonstrates that the main characteristics of myotonic reaction are: persistence and slow subsidence on foradic stimulation, and the double reaction of the muscle to galvanic stimulation. *Stability:* Physicians. *Quality:* Fair. *Source:* F. A. Quadfasel, M.D., Cushing Veterans Administration Hospital, Framingham, Mass.

ELECTRO DIAGNOSTIC PROCEDURES (15', B & W, Sound, USA PMF 5066 MF 1042). Demonstration of electrodiagnostic procedures with stimulation currents. Material needs additional explanation. *Suitability:* Physicians, therapists. *Quality:* Fair. *Source:* USA.

ELECTRO MYOGRAPHIC PROCEDURE (15', B & W, Sound, PMF 5067, MF 1403). Demonstration of apparatus and technique. *Suitability:* Physicians, therapists. *Quality:* Fair. *Source:* USA.

THE ELECTRON—AN INTRODUCTION (16', B & W, Sound, OE 175). Produced by the U. S. Office of Education; explains the nature of electrons, electron flows and electromotive force. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* (for purchase only at $27.88), Castle Films, 30 Rockefeller Plaza, New York.

EMPLOYING BLIND WORKERS IN INDUSTRY (17', B & W, Sound, OE 165). Produced by the U. S. Office of Education; shows selective placement of the blind in industry. *Suitability:* Therapists, ancillary personnel. *Quality:* Good. *Source:* (for purchase only), Castle Films, 30 Rockefeller Plaza, New York; (Rental) NYU.

EMPLOYING DISABLED WORKERS IN INDUSTRY (20', B & W, Sound, OE 166). Produced by the U. S. Office of Education; demonstrates the selective placement of the handicapped in industry. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* (for purchase only at $32.16), Castle Films, 30 Rockefeller Plaza, New York.

ESTABLISHING WORKING RELATIONS FOR THE DISABLED WORKER (14', B & W, Sound, OE 401). Produced by the U. S. Office of Education; shows the tact and judgment which a supervisor must use in establishing working relationships for a disabled worker. *Suitability:* Therapists, ancillary personnel. *Quality:* Good. *Source:* (for purchase only at $25.76), Castle Films, 30 Rockefeller Plaza, New York.

FIRST STEPS (10' B & W, Sound). Academy Award winning documentary on the rehabilitation of cerebral palsied children at Camp Oakhurst, the camp of the New York Service for Orthopedically Handicapped Children. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* Film Program Services, 1173 Sixth Avenue, New York 19.

FORGOTTEN CASUALTY (12', B & W, Sound). A fund raising film which shows the need for increased facilities and training for civilian rehabilitation. *Suitability:* Physicians, ancillary personnel. *Quality:* Good. *Source:* IRPM.

FREIDREICH'S HEREDITARY ATAXIA AND LITTLE'S DISEASE (16', B & W, Silent). A clinical study. *Suitability:* Physicians. *Quality:* Good. *Source:* NYU.

FUNDAMENTALS OF MASSAGE (12', B & W, Sound, OE 414). Produced by the U. S. Office of Education; shows methods and value of massage. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* AMA.

HALF A CHANCE (11', B & W, Sound, USA Misc. 1254). Sports for amputees. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* USA.

HELPING THE BLIND TO HELP THEMSELVES (21', Color, Sound). Shows the emotional readjustment and retraining of the blind at the Industrial Home for the Blind, Brooklyn. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* The Industrial Home for the Blind, 520 Gates Avenue, Brooklyn 16, New York.

HYDROTHERAPY (22', B & W, Sound, OE 410). Produced by the U. S. Office of Education; illustrates methods and techniques of hydrotherapy. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* AMA.

THE INSTITUTE OF REHABILITATION AND PHYSICAL MEDICINE (30', Color, Sound). Presents the organization and activities of the Institute of Rehabilitation and Physical Medicine of the New York University-Bellevue Medical Center, New York. *Stability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* IRPM.

INSTRUCTING THE BLIND WORKER ON THE JOB (17', B & W, Sound, OE 166). As titled. *Suitability:* Therapists, ancillary personnel. *Quality:* Good. *Source:* (for purchase only at $28.58), Castle Films, 30 Rockefeller Plaza, New York.

INSTRUCTING THE DISABLED WORKER ON THE JOB (14', B & W, Sound, OE 400). Produced by the U. S. Office of Education; shows how the attitude of an instructor toward a disabled person can affect his success or failure in learning a job. *Suitability:* Therapists, ancillary personnel. *Quality:* Good. *Source:* (for purchase only at $25.71), Castle Films, 30 Rockefeller Plaza, New York.

LEG AMPUTATION BELOW THE KNEE AND APPLICATION OF ARTIFICIAL LIMB (15', Color, Silent). As titled. *Suitability:* Physicians. *Quality:* Good. *Source:* Orthopedic Appliance and Limb Manufacturers' Association, 336 Washington Building, Washington 5, D. C.

LIFE BEGINS AGAIN (22', B & W, Sound). Produced by the British Information Service; shows the medical and psychological rehabilitation of both military and civilian casualties. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* NYU.

LIMBS TO ORDER (10', B & W, Sound). Shows therapeutic treatment, exercise and fitting and training in the use of artificial limbs by Canadian battle casualties. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* National Film Board of Canada, 620 Fifth Ave., New York 20, N. Y.

MASSAGE (5', B & W, Silent). Produced in 1938 by the Council on Physical Medicine of the American Medical Association. *Suitability:* Physicians, therapists. *Quality:* Fair. *Source:* AMA.

MEET MCGONEGAL (12', B & W, Sound, USA Misc. 956). An inspirational and orientation film for arm amputees. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* USA.

NEW FACES COME BACK (28', B & W, Sound). Produced by the Royal Canadian Air Forces and the National Film Board of Canada. Shows rehabilitation and social adjustment following plastic surgery. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* National Film Board of Canada, 620 Fifth Avenue, New York 20, New York.

NEW HORIZONS (30', B & W, Sound). Gives over-all orientation to the use of physical medicine showing latest methods and equipment. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* NFIP.

OUT OF BED INTO ACTION (17', B & W, Sound, USA TF 1-3708). A patient orientation film illustrating the AAF Convalescent Training Program. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* USA, NYU.

PIONEERING FOR AMERICA'S CHILDREN (30', Color, Sound). Shows recent developments in the early care, therapeutic management and follow-up of cerebral palsy cases. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* Cerebral Palsy Society of New York City Inc., 235 W. 102nd St., New York City.

PRINCIPLES OF GAS-FILLED TUBES (15', B & W, Sound, OE 353). Produced by the U. S. Office of Education; explains theory of ionization applied to gas-filled tubes and use of the gas diode and gas triode. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* (for purchase only at $27.15), Castle Films, 30 Rockefeller Plaza, New York.

PROGRESSIVE MUSCULAR ATROPHIES, DYSTROPHIES AND ALLIED CONDITIONS (25', B & W, Silent). Distinctive diagnostic features in the illustrative cases for each of these groups. *Suitability:* Physicians. *Quality:* Good. *Source:* NYU.

RADIOTHERAPY: HIGH DOSAGE TREATMENT (17' B & W, Sound, OE 411). Produced by the U. S. Office of Education; demonstrates the nature, effects and methods of the use of X-Ray. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* AMA.

RECONDITIONING CONVALESCENTS FOR RETURN TO DUTY (30', B & W, Sound, USA TF 8-2070). Presents scope, significance and operation of the reconditioning program in Army hospitals. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* USA.

RECONDITIONING IN THE ETO (30', B & W, Sound, USA Misc. 1081). Presents the Army occupational and physical reconditioning program in the European Theatre of Operations. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Fair. *Source:* USA.

RECREATIONAL AND OCCUPATIONAL THERAPY (14', B & W, Sound, OE 415). Produced by the U. S. Office of Education; illustrates techniques and equipment used in recreation and occupational therapy. *Suitability:* Physicians, therapists and ancillary personnel. *Quality:* Good. *Source:* AMA.

REHABILITATION OF CHRONIC NEUROLOGICAL CASES (20', B & W, Sound). Shows model rehabilitation program at the Minneapolis VA Hospital; follows typical patient through rehabilitation. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Excellent. *Source:* Veterans Administration, Washington 25, D. C.

RETURN TO ACTION (20', B & W, Sound). Produced by the British Ministry of Labour; shows occupation rehabilitation of the disabled. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* British Information Services, 30 Rockefeller Plaza, New York 20, N. Y.

THE ROAD TO RECOVERY (40′, B & W, Sound, USA TF1-3463). Presents the Army Air Forces rehabilitation program with case histories of an amputee, cardiac and a neuropsychiatric patient. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Excellent. *Source:* USA.

SAINT MARTIN'S CLINIC, NYMEGAN, THE NETHERLANDS (20′, B & W, Silent). Shows the making of prostheses and case histories of child and adult war amputees using prostheses in the activities of daily living and other specialized activities. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* Foster Parents Plan for War Children, Inc., 55 W. 42nd St., New York City.

SCHOOL OF ANOTHER CHANCE (15′, B & W, Sound). Shows the vocational training program for disabled persons at the Institute for the Crippled and Disabled in New York. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* ICD.

THE SKY IS THE LIMIT (20′, Color, Sound, USA Misc. 1249). Prior walking technique for a unilateral AK amputee and the capabilities he can achieve. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* USA.

SOCIAL ADJUSTMENT OF THE BLINDED SOLDIER (27′, B & W, Sound, USA PMF 5035, MF 1296). As titled. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* USA.

SPINAL CORD LESIONS (30′, B & W, Sound). Shows the rehabilitation and retraining of paraplegic patients at the Institute for the Crippled and Disabled, New York. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Source:* ICD.

A STUDY OF PERIPHERAL NERVE LESIONS (20′, Color, Silent). A study of function of the muscles of the shoulder girdle following lesions of certain peripheral nerves. Prepared by the U. S. Naval Hospital, Mare Island, Calif. *Suitability:* Physicians, therapists,. *Quality:* Good. *Source:* American Physical Therapy Assn., 1790 Broadway, New York 19, N. Y.

SWINGING INTO STEP (33′, B & W, Sound, USA TF 8-2083). The Army rehabilitation program for amputees. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* USA.

TEACHING CRUTCHWALKING (13′, B & W, Sound, OE 412). Produced by the U. S. Office of Education: Shows techniques of teaching crutchwalking. *Suitability:* Physicians, therapists, patients. *Quality:* Good. *Source:* (for purchase only at $23.61), United World Films, 445 Park Avenue, New York City.

THERAPEUTIC EXERCISE—INTRODUCTION (20′, B & W, Sound, USA PMF 5034, MF1288). As titled. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* USA.

THERAPEUTIC EXERCISE—ORTHOPEDICS (30′, B & W, Sound, USA PMF 5051, MF 1289). As titled. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* USA.

THERAPEUTIC EXERCISES—PERIPHERAL NERVE INJURIES (18′, B & W, Sound, USA PMF 5053, MD1290). As titled. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* USA.

THERAPEUTIC EXERCISE—TENDON TRANSPLANTS (15′, B & W, Sound, USA PMF 5054, Misc. 1291). As titled. *Suitability:* Physicians, therapists. *Quality:* Fair. *Source:* USA.

THERAPEUTIC EXERCISE—THORACIC SURGERY (27′, B & W, Sound, USA PMF 5056, MF 1293). As titled. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* USA.

THERAPEUTIC USES OF HEAT AND COLD: PART I ADMINISTERING HOT APPLICATIONS (22′, B & W, Sound, OE 408). Produced by the U. S. Office of Education; as titled. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* AMA.

THERAPEUTIC USES OF HEAT AND COLD: PART II ADMINISTERING COLD APPLICATIONS (21′, B & W, Sound, OE 409). Produced by the U. S. Office of Education; as titled. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* AMA.

THEY DO COME BACK (22′, B & W, Sound). Illustrates the rehabilitation of the tuberculous. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* National Tuberculosis Association, 1790 Broadway, New York 19, N. Y.

TO HEAR AGAIN (37′, B & W, Sound, USA PMF 5052, MF 1316). Shows the Army aural rehabilitation program. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* USA.

TOWARDS INDEPENDENCE (25′, B & W, Sound, USA PMF 5055). A teaching and orientation film on paraplegia. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Excellent. *Source:* USA.

TRAINING FOR THE DISABLED (20′, B & W, Sound). Produced by St. Loyes College and Queen Elizabeth's Hospital in cooperation with the Ministry of Labour and National Service, England; shows medical and vocational rehabilitation. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* AMA.

THE TRIODE (14′, B & W, Sound, OE 177). Produced by the U. S. Office of Education; explains electric field in diode and triode, amplification, distortion and reviews the triode principle. *Suitability:* Physicians, therapists. *Quality:* Good. *Source:* AMA.

UNDERWATER EXERCISES (16′, B & W, Silent). Produced in 1938 by the Council on Physical Medicine of the American Medical Association. Demonstrates underwater exercises given to cases of infantile paralysis, cerebral palsy, etc. *Suitability:* Physicians, therapists. *Quality:* Fair. *Source:* AMA.

VOCATIONAL TRAINING FOR THE HANDICAPPED (18', Color, Sound). As titled. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* California State Bureau of Vocational Rehabilitation, Merchants National Bank Building, 705 California Street, Sacramento 14, California.

VOYAGE TO RECOVERY (30' Color, Sound, USN MN 4330a). Explains the coordination of all services in the U. S. Navy rehabilitation program. *Suitability:* Physicians, therapists, ancillary personnel. *Quality:* Good. *Source:* AMA; NYU.

WINNING AGAINST ODDS (14', B & W, Sound). Shows the selective placement of disabled workers at the Caterpillar Tractor Company. *Suitability:* Physicians, therapists, ancillary personnel, patients. *Quality:* Good. *Source:* NYU.

SOURCES:

(For organizations with more than one film listed)

AMA American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

ICD Institute for the Crippled and Disabled, 400 First Avenue, New York, New York.

IRPM Institute of Rehabilitation and Physical Medicine, New York University-Bellevue Medical Center, 327 East 38th Street, New York 16, New York.

NFIP National Foundation for Infantile Paralysis, Inc., 120 Broadway, New York 5, New York.

NYU Film Library, New York University, 26 Washington Place, New York 3, New York.

USA Application forms may be obtained by writing the Commanding General of the Army Area concerned, Attention: The Surgeon. Army Areas, addresses and the states they service are:
HQ, First Army, Governor's Island, New York: Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, Delaware, New York.
HQ Second Army, Ft. George G. Meade, Maryland, Pennsylvania, Maryland, West Virginia, Virginia, Ohio, Indiana, Kentucky.
HQ Third Army Post Office Building, Atlanta, Georgia; North Carolina, South Carolina, Georgia, Florida, Alabama, Tennessee, Mississippi.
HQ Fourth Army, Ft. Sam Houston, Texas; Texas, Oklahoma, New Mexico, Arkansas, Louisiana.
HQ Fifth Army, 1660 East Hyde Park Blvd., Chicago 15, Illinois; Iowa, Nebraska, Illinois, N. Dakota, Michigan, S. Dakota, Wyoming, Colorado, Missouri, Kansas, Minnesota, Wisconsin.
HQ Sixth Army, Presidio, San Francisco, California; Washington, Arizona, Oregon, Utah, Idaho, Montana, California, Nevada.

1ST LT. MILDRED BOND HONORED

Mildred V. Bond, 1st Lt., WMSC (OT), was selected by the Board of Management of the A.O.T.A. as the candidate to receive the Career Girl Award which is made by the Women's International Exposition.

Following graduation from Milwaukee-Downer College in 1942, Lt. Bond was a member of the staff of the Curative Workshop of Milwaukee until she volunteered for Army service in 1944. She was Chief Occupational Therapist, first at Ashford General Hospital, then at Percy Jones General Hospital, before being assigned in May, 1948, to the Physical Medicine Consultants Division, Office of the Surgeon General, as Assistant, Occupational Therapy Branch. Having been chosen from all occupational therapists in the Army for a year's graduate study, Lt. Bond is now a candidate for the Master's Degree in Occupational Therapy at the University of Southern California.

SOUTH AFRICA OPPORTUNITY

The following letter is made public by the Educational Office of the Association so interested occupational therapists may be made aware of this opportunity to work in South Africa:

Dear Madam,

I am anxious to work in America in order to extend my experience and to study American educational methods in Occupational Therapy.

To enable me to do this I have applied to the University Authorities here to allow me to arrange an exchange of jobs with an American Occupational Therapist for one year.

It is the policy of the University Council to encourage such exchanges in order to correlate and exchange information on educational problems. I have, therefore, been asked to make the initial enquiries.

I am a lecturer in Occupational Therapy and came from England in 1943 to start the course in Occupational Therapy at this University.

I shall be grateful if you will tell me if your Association approves of this policy and whether it would help in arranging such an exchange.

If such is the case, I will give you detailed information about myself and conditions here on receipt of your reply.

ISABEL MACARTHUR

Occupational Therapy Department Medical School, University of the Witwatersrand Johannesburg, South Africa

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